# EMAILS FROM CANETANA HURD

**Kathy Jones**

**From:** Lawrence Lue <lawrencejlue@gmail.com>
**Sent:** Friday, March 23, 2018 10:50 AM
**To:** Canetana Hurd
**Subject:** Fwd: Letter from MHC to BOS re B+C
**Attachments:** B&CLtr2BOS.1.doc

Hi Cy,

Can you use the electronic signature I provided before?

Larry

---------- Forwarded message ----------
From: **Lawrence Lue** <lawrencejlue@gmail.com>
Date: Fri, Mar 23, 2018 at 10:48 AM
Subject: Re: Letter from MHC to BOS re B+C
To: Canetana Hurd <CHurd@dmh.lacounty.gov>
Cc: Brittney Weissman <brittney@namilaccc.org>, Commissioner Dalgleish <commissionerstacydalgleish@gmail.com>

Hi all,

Thank you, Brittney, this was really helpful.

Attached please find my suggested revision of the first paragraph of the letter to the Board. Cy, please forward as Brittney has indicated.

Larry

On Thu, Mar 22, 2018 at 4:07 PM, Canetana Hurd <CHurd@dmh.lacounty.gov> wrote:

Letter placed on letterhead, formatted and ready for review. Report attached

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**From:** Brittney Weissman [mailto:brittney@namilaccc.org]
**Sent:** Thursday, March 22, 2018 12:35 PM
**To:** Canetana Hurd; Lawrence Lue
**Cc:** stacy dalgleish
**Subject:** Letter from MHC to BOS re B+C

Hi Cy and Larry —

I've taken the liberty of drafting a letter from Larry and the MHC to the BOS re the approved Board and Care report. Please see attached and, if acceptable, sign and place on letterhead, attach the report and email to each Board office, health deputy, homelessness deputy, Supervisor, CEO's office, etc. Also send to Mary Marx, Mimi McKay, Caroline Kelly, all commissioners, anyone else. I think Caroline offered to send any email address for anyone mentioned here. You can send the letter from my attention if that's more appropriate. I leave that to you.

Please let me know if this can be submitted today or tomorrow. I'm hoping that's the case.

Let me know if you have questions.

Thanks,

Brittney

Brittney Weissman

Executive Director

NAMI Los Angeles County Council

3250 Wilshire Boulevard, Suite 1501

Los Angeles, CA 90010

(818) 687-1657

Brittney@namilaccc.org

http://secure-web.cisco.com/1h9TDgN50ZXXmCawfNGnVdubxmFBTpjXGP71qthJHu1IHvx9IRSB7wWccHvFKCG0JOwyz2hiewVZky779JGuNbO8OZ1wRLp84DIPHJuRUM9FL2z8kbLFS5rtPa4Q2BKAuNo8KIMMiQ276b5zYrxdKS80UVUfGg05E-_1Rs_xqDD5BNmB0w9GHyGZw-h3NOhjFI_d_93kRIremM9sRAXu_8gQghprf2Mu6ysyxSPiqhqAg_zqLwAAO3mx96VDbNqL7ZP45MGmdAWi4NRoFnL10oUZJ5-t89wJF53217sKqZHNaYQzqVmgRiLvsa6-3Ik56h6FZFCgD8Ne_an3SCel8GqY-yfcBuf7tMWXWxXKkxhPhkyLKpEQIdZ5P5-JBVsvW/http%3A%2F%2Fwww.namilacc.org

www.facebook.com/NAMILACC.org

NAMI Los Angeles County Council
National Alliance on Mental Illness

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Lawrence J. Lue
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213-952-8892 (Cell)
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# Los Angeles County
# Mental Health Commission
"Advocacy, Accountability and Oversight in Action"

March 22, 2018

Via E-Mail
Honorable Board of Supervisors
County of Los Angeles
Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

[redacted]

**Kathy Jones**

**From:** Brittney Weissman <brittney@namilaccc.org>
**Sent:** Thursday, March 22, 2018 12:35 PM
**To:** Canetana Hurd;Lawrence Lue
**Cc:** stacy dalgleish
**Subject:** Letter from MHC to BOS re B+C
**Attachments:** 3.22.18 MHC to BOS re Board and Cares.docx

Hi Cy and Larry —

I've taken the liberty of drafting a letter from Larry and the MHC to the BOS re the approved Board and Care report. Please see attached and, if acceptable, sign and place on letterhead, attach the report and email to each Board office, health deputy, homelessness deputy, Supervisor, CEO's office, etc. Also send to Mary Marx, Mimi McKay, Caroline Kelly, all commissioners, anyone else. I think Caroline offered to send any email address for anyone mentioned here. You can send the letter from my attention if that's more appropriate. I leave that to you.

Please let me know if this can be submitted today or tomorrow. I'm hoping that's the case.

Let me know if you have questions.

Thanks,
Brittney

Brittney Weissman
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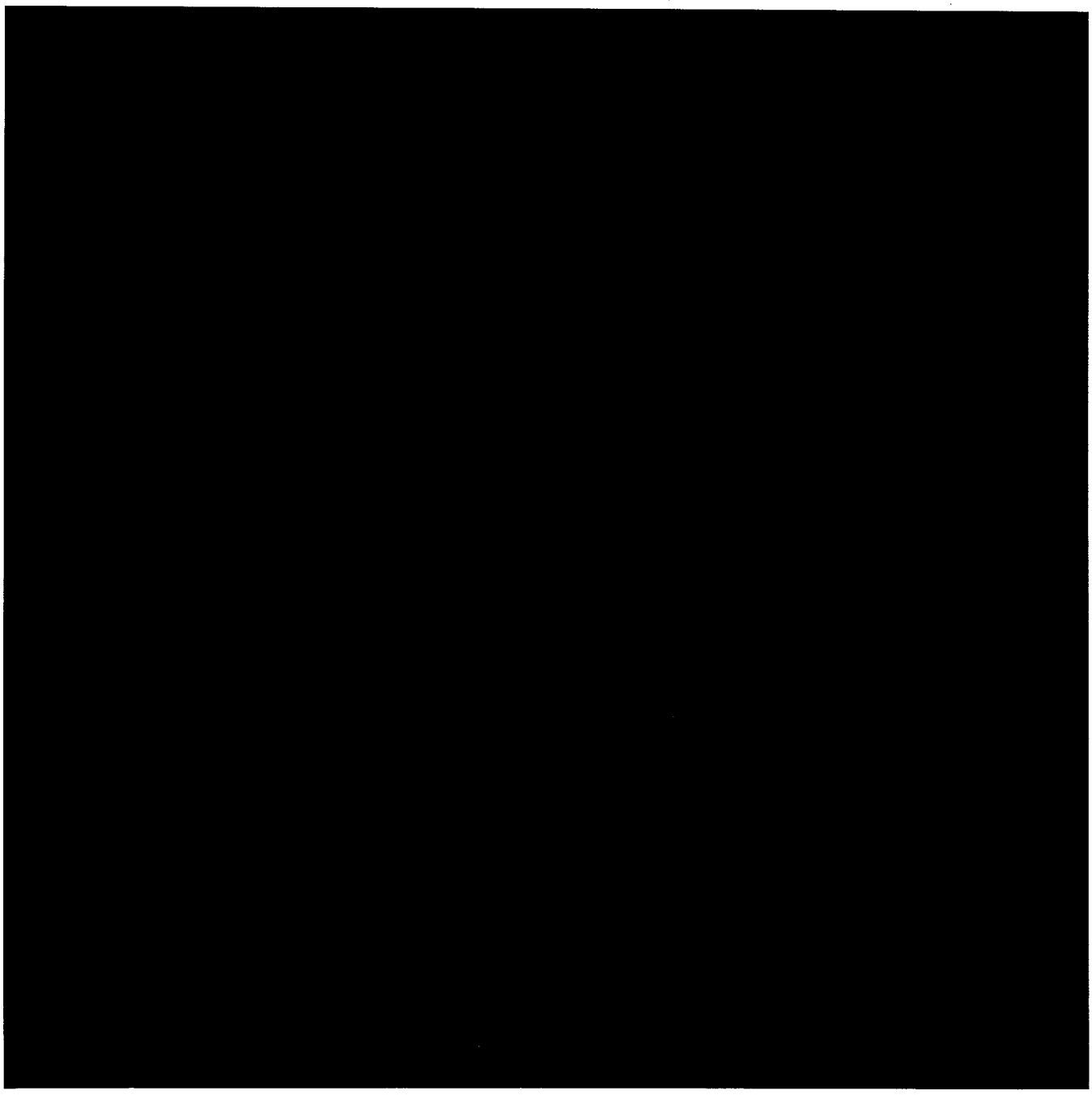
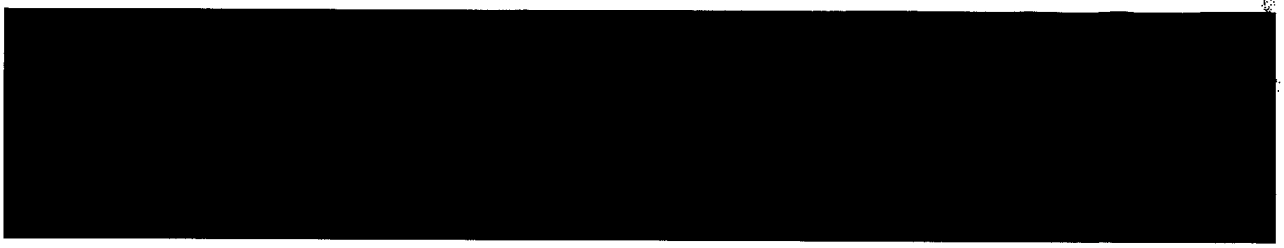
NAMI National Alliance on Mental Illness | Los Angeles County Council

[Place on MHC Letterhead]

March 22, 2018

Via E-Mail
The Honorable Members of the Board of Supervisors
County of Los Angeles
Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012





**Kathy Jones**

**From:** Brittney Weissman <brittney@namilaccc.org>
**Sent:** Monday, March 12, 2018 12:07 PM
**To:** stacy dalgleish
**Cc:** Canetana Hurd
**Subject:** Re: Board and Care report to SAACs

Awesome, Stacey! I know Barbara Wilson and Kerry Morrison were also sending them out, but I haven't checked in on the status lately. I'll do that and let you know!

Brittney

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
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Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
http://secure-web.cisco.com/1jNvnI9DPMkvNVICDMygawrCFEBEuRcT5_f8HpzVZtNB64rFYGUF5huevkTKwiNBU887-xAKhsySokQR_9Bis-zLaGil8YwVUP5Rm2SPABcccpa6N3WENS4zojPOjPrPoGXhVNBthXz0qXaL4ll1gbb4QBOb4egl44FF8d8ENRMNFsgrKW-qpqd67Bq-RthpThqMvFxYmJAfDQGjiOFwuAwNPuEMjb99eoNPvq08Efm3vwfzxvp7hJ1jMHNMYQY4FTQ9pW7p87ll2hzXM4RmjUZuz1kxrwsmce9f5tn6O90UGH7gM90UFi-dP3U5tlE0mTLHvxydQ1m_-7h3zlD3dEgGmACAtL85WGcUem8lzTGSrAqcV0yBgrr-2slly7jbUkJ7HxKQynLqD1bcnmEtZCw/http%3A%2F%2Fwww.namilacc.org
www.facebook.com/NAMILACC.org

On Mar 12, 2018, at 11:08 AM, stacy dalgleish <commissionerstacydalgleish@gmail.com> wrote:

Thanks Brittney,
I'm sending it to our Santa Monica City Council and the Housing and Social Services Commissioners. If you think of any other groups, let me know and I'll send to them.

On Mar 12, 2018, at 10:29 AM, Brittney Weissman <brittney@namilaccc.org> wrote:

Hi Cy — I wanted to follow up on a request from Reba at the last MHC meeting to get the Board and Care report out to the SAACs. How would I do that?

Thanks,
Brittney

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
3250 Wilshire Boulevard, Suite 1501
Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
http://secure-web.cisco.com/1jNvnI9DPMkvNVICDMygawrCFEBEuRcT5_f8HpzVZtNB64rFYGUF5huevkTKwiNBU887-xAKhsySokQR_9Bis-zLaGil8YwVUP5Rm2SPABcccpa6N3WENS4zojPOjPrPoGXhVNBthXz0qXaL4ll1gbb4QBOb4egl44FF8d8ENRMNFsgrKW-qpqd67Bq-RthpThqMvFxYmJAfDQGjiOFwuAwNPuEMjb99eoNPvq08Efm3vwfzxvp7hJ1jMHNMYQY4FTQ9pW7p87ll2hzXM4RmjUZuz1kxrwsmce9f5tn6O90UGH7gM90UFi-dP3U5tlE0mTLHvxydQ1m_-7h3zlD3dEgGmACAtL85WGcUem8IzTGSrAqcV0yBgrr-2sIly7jbUkJ7HxKQynLqD1bcnmEtZCw/http%3A%2F%2Fwww.namilacc.org
www.facebook.com/NAMILACC.org

<LACC_colorlowres.jpg>

**Kathy Jones**

**From:** Canetana Hurd
**Sent:** Tuesday, February 13, 2018 3:02 PM
**Subject:** Board and Care Report - A Call to Action
**Attachments:** Report to LACMH Commission re BoardCare draft 3.pdf

SAAC Co-Chairs,

Per your request, attached is the report on the Board and Care system discussed at the MHC/SAAC Co-Chair's meeting on 2/13/18

**Kathy Jones**

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**From:** Caroline Kelly <carolinekelly3@gmail.com>
**Sent:** Tuesday, March 20, 2018 6:35 PM
**To:** Canetana Hurd;Commissioner Lue
**Subject:** Fwd: FW: Prop HHH Citizens Oversight Committee Meeting 2/16/18: Agenda and Materials
**Attachments:** Item 6 - Board and Care Facilities.pdf; Agenda Packet.pdf

Here is the PDF version of our report that we presented before the HHH committee.

# A Call to Action: The Precarious State of the Board and Care System Serving Residents Living with Mental Illness in Los Angeles County

## Draft 1/22/18


**Prepared by the**

**Los Angeles County Mental Health Commission**

**Ad-hoc Committee on LA County's Board and Care System**

**Members**

Caroline Kelly, Immediate Past Chair LA County Mental Health Commission

Barbara B. Wilson, LCSW

Kerry Morrison, Stanton Fellow 2016-17

Brittney Weissman, NAMI LA County Chapter

Table of Contents




*Insane Consequences: How the Mental Health Industry Fails the Mentally Ill.* DJ Jaffe. Prometheus Books, New York. 2016.

California Mental Health Planning Council: Adult Residential Facilities (ARF's): Highlighting the critical need for adult residential facilities for adults with serious mental illness in California. October 2017.

CA Association of Local Behavioral Health Boards & Commissions October 11, 2017 Older Adult / Residential Care Facility Ad Hoc Committee. ISSUE BRIEF: Adult Residential Care Facilities – The Critical Need

**STATEMENT OF THE PROBLEM**

Board and care homes (technically referred to as Adult Residential Facilities) represent a precious and affordable housing resource for individuals suffering from mental illness. These facilities range in size from 6 beds (in a single-family home) to 100+ beds. They are privately operated by homeowners or for-profit corporations. Adult Residential Facilities are 24-hour, non-medical community facilities regulated by the state Community Care Licensing Division. Residents present a continuum of need, ranging from those able to hold down a job on one end of the spectrum, to those who have been released from locked psychiatric facilities on the other end of the spectrum. Yet despite this continuum of need, the daily "rent" paid to a board a care operator in LA County is $35.[1] Operators of board and care homes are increasingly questioning the sustainability of this business model in the face of increasing costs on all fronts (increases in minimum wage, insurance costs, utility increases and accumulated deferred maintenance).

In a preliminary canvasing of board and care operators, the Department of Mental Health believes that in Service Area 2 alone, there may be a closure and loss of as many as 400 beds over the next 18 months. Extrapolated across the county, this results in a significant loss that outpaces the additional housing currently being planned.

Further, given the service needs of this population, the meagre reimbursement does not provide for any type of therapeutic enrichment, community-building or case management.

The board and care system for mentally ill residents is a non-sustainable business model and does not contribute to a meaningful treatment environment which will contribute to a quality of life and/or prevent residents falling back into homelessness. Absent a corrective action, this housing resource will continue to erode.[2]

## I. SOLUTION SNAPSHOT

There needs to be an infusion of resources – this year -- into the board and care system to ensure its survival. Supplemental funding, above and beyond what the residents can pay through their government benefits,[3] would provide incentives to operators to continue housing people living with mental illness. The infusion needs to be substantial enough to forestall the loss of precious beds through: (1) the closure of these facilities, (2) the sale of these properties for residential or commercial

[1] For this reimbursement, the board and care must provide three meals a day plus two snacks, a room and bedding, laundry, a well-maintained and safe facility, money management and access to health or psychiatric care professionals.

[2] The long-awaited study from the California Mental Health Planning Council (CMHPC), October 2017, started its report by saying: "This issue paper is the beginning of an effort to highlight a significant public health issue: **the lack of adult residential facilities as housing options for individuals with serious mental illness in California."**

[3] According to the CHMPC October 2017 report, "monthly rates charged by ARF's are driven by the amount of the Social Security Income/State Supplemental Payment (SSI/SSP) amount paid to Californian's with disabilities and who are unable to work. The SSI/SSP payment, as sole source f payment for the individual residing in an ARF, is not sufficient to provide adequate income for the operation of a licensed ARF especially when some about of the SSI/SSP payment is set aside for personal needs of the individuals. Therefore subsidies, often called "patches" are needed." Page 6.

development, or (3) the conversion of these facilities to those serving other populations which offer a higher daily rental rate (e.g., $85 – $150 for homes for individuals with intellectual disabilities).[4]

Four options are worth exploring to provide these supplemental resources:

a. Reestablishment of the supplemental funding that was made available to LA County board and care facilities up until approximately nine or ten years ago when the head of county DMH Dr. Marvin Southard eliminated this program—and not just to a few places that will take more special cases;
b. Allocation of a portion of the "No Place Like Home" $2B funding that will become available, representing a re-direction of funds already available through the Prop 63 Millionaire's Tax. These funds could be deployed to counteract the deferred maintenance associated with many of these facilities and serve as a source of capital investment.
c. Tapping into a portion of the funds that have been made available through Measure HHH, the LA City general obligation bond to support permanent supportive housing for chronically homeless individuals, which city voters approved in November 2016;
d. Tapping into county funds raised Measure H, passed by county voters on the March 2017 ballot.

## II. BACKGROUND

### a. Residential Options for Persons Living with Mental Illness

People living with a serious mental illness account for less than six percent of the population[5]. With the shift away from state institutions that commenced in the last 1970's, and the lack of community-based treatment programs and facilities that were promised as an alternative, hundreds of thousands of individuals in the US suffering from mental illness have either been "reinstitutionalized" in prisons and jails, or are homeless. The remainder who have housing are primarily in one of three places:

- Living at home with family
- Living in permanent supportive housing as part of the "Housing First" movement to move people experiencing homelessness from the street into a living unit
- Living in privately operated "board and care" facilities.

In Los Angeles County, where the most recent point-in-time homeless count identified 57,794 homeless people, the number of people living with mental illness far exceeds the housing options available. The 2017 demographic survey conducted by the Los Angeles Homeless Authority (LAHSA) identified that 30 percent of the homeless population in Los Angeles County suffers from a serious mental illness. That would amount to approximately 15,728 people.

Further, the Los Angeles County jail is generally characterized as one of the largest mental institutions in the country, with over 4,700 inmates incarcerated suffering from mental illness.

[4] "Disparities in Reimbursement Rates." Chart prepared by Barbara B. Wilson, LCSW, is attached as an Exhibit.
[5] Source: *Insane Consequences* by DJ Jaffee, referencing research conducted at the time SAMHSA's Center for Mental Health Services was created. The definition defines serious mental illness in adults as, "those mental illnesses that met the criteria of [latest edition of] DSM and ... resulted in functional impairment which substantially interferes with or limits one or more major life activities."

With the expressed city/county goal to end chronic homelessness in LA County, which is a national objective as well, attention must be paid to all housing options available, or in the pipeline, to house people living with mental illness.

This report shines a light on the state of the board and care system in L.A. County, which represents a precious housing resource for people living with mental illness. The board and care system provides a residential setting for adults and provides supervision, support, protection and security in a group setting. The provider must be licensed by the Department of Health and Human Resources, Office of Health Facilities Licensure and Certification.

Last year, Los Angeles County managed to house over 14,000 people, a record amount and yet still ended up with an increase of 23% in its homeless population. Analysis points to many reasons with significant ones being the erosion of current affordable housing stock and issues of NIMBYism when it comes to the development of more affordable housing.

The board and care system is precariously resourced and prospects for the continued vitality of this system in the wake of shockingly low daily rental rates per resident ($35) is jeopardized. The failure of this system could exacerbate the homeless situation in LA County with residents exiting board and cares back into homelessness and/or board and care facilities no longer being available to accept new residents.

b. Types of Adult Residential Facilities (ARF's)

Adult Residential Facilities[6] are regulated by the Community Care Licensing Division (CCLD) of the State of California. The provisions are articulated in the Community Care Facilities Act of the Health and Safety Code. Typically, the services provided by an ARF include lodging, food service, care and supervision[7], assistance with taking medications in accordance with a physician's order, assistance with transportation to medical and dental appointments, planned activities, housekeeping, laundry service and maintenance or supervision of cash reserves.

The Community Care Licensing Division oversees several types of residential and day facilities (e.g., Residential Care Facilities for the Chronically Ill, or Residential Care Facilities for the Elderly, to name just two) but for the purposes of this report, we are focusing on what is typically referred to as a board and care, or ARF, in the vernacular of the state.

ARF's may serve people suffering from a mental illness, people with developmental disabilities or elderly residents. They generally do not provide skilled nursing services, with some exceptions.[8]Some facilities

[6] An Adult Residential Facility means any facility of any capacity that provides 24-hour a day nonmedical care and supervision to the following: (A) persons 18 years of age through 59 years of age; and (B) persons 60 of age and older only in accordance with Section 85068.4 (Acceptance & Retention Limitations) [Source: Community Care Licensing Division (CCLD) report presented by Claire Matsushita, Asst. Program Administrator, to LA County Mental Health Commission on April 27, 2017.]

[7] "Care and Supervision" means those activities which, if provided, shall require the facility to be licensed. It involves assistance as needed with activities of daily living and the assumption of varying degrees of responsibility for the safety and well-being of the residents. [Source: CCLD report]

[8] According to the CMHPC report, "Residential care facilities are not allowed to provide skilled nursing services, such as give injections nor maintain catheters nor perform colostomy care (unless there is a credentialed RN or

are exempted from the CCL licensing process, and there is anecdotal evidence that some formerly licensed board and care homes are shifting to the unlicensed domain. For example, a home or facility that supplies room and board only, with no elements of personal care, is not licensed. These facilities operated "under the radar" and are not subject to any type of regulatory oversight. Recovery houses for persons recovering from substance abuse are also not licensed.

c. The Inventory

The challenge of this research has been to identify the trends with respect to available beds for persons suffering from mental illness. Anecdotal evidence suggests that board and care operators are closing down their facilities and selling their property *at an alarming rate*. While the department has kept track of board and care facilities that it has contracts with, this pool is small compared to all inventory. In meetings with DMH department staff in Q4 2017, we asked for:

- Trends over a two to five-year period documenting number of facilities closing and number of beds impacted.
- Breakdown of current inventory of housing for mentally ill as compared to elderly or intellectual disabilities.
- Information about all board and care facilities in the county, not just those with whom the county has an agreement.

As they say, you can't manage what you don't measure, so the lack of data is an impediment to any effort to stem the loss of more beds for this population.

DMH is in the process now of ramping up its efforts to track this information. This positive development is in part due to the internal resetting of priorities and emphasis under the new Director. We also believe that this invigorated effort is in part in response to this Ad Hoc Committee's work. The timing and request of the recent motion by the Board of Supervisors to track housing for a real time data base has also been a significant factor. In response to the Board Motion DMH has assigned staff to move forward with soliciting and developing a resource manager and locator for 24hr services. They are currently doing a process improvement analysis to help determine what the scope and functionality of the application needs to be. They still will need to use that scope to find the best application for this need.

**This process is not yet complete though and *we ask the Board to continue to expect, encourage and enable the department to gather this information.***

The Mental Health Commission organized presentations on this topic at the April 27, 2017 general commission meeting. At that time, which is still the most current data we have, **CCLD reported that in Los Angeles County there are 1,283 Adult Residential Facilities with a bed capacity of 11,979.**

LVN individual working in the home), but they can provide assistance with all daily living activities, such as bathing, dressing, toileting, urinary or bowel incontinency care." P. 3.

What we have not been able to determine is the breakdown of population served by these facilities. At a minimum, these would be important data points to track:

- Current number of facilities serving people suffering from mental illness. Number of beds and ***how this has changed over time.***
- Current number of facilities serving people living with intellectual disabilities and change over time.
- Current number of facilities serving adult elderly or other needs and change over time.

Absent this data, it is impossible to provide a snapshot of trends. Anecdotal evidence, however, suggests that there is an erosion of bed availability for persons with mental illness due to either closure of facilities for economic reasons, shift to an unlicensed facility[9] or conversion to serve a population where the reimbursement rate is higher. This anecdotal trend also begs the question: are there any new facilities coming on line to add beds to a system that appears to be stressed? If not, what is the reason for lack of entry into this market?

Further, it would be important to know how many *unlicensed* board and care facilities in the county serve persons with mental illness. An unlicensed facility will sometimes recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. These facilities will vary wildly in quality and in the degree of services provided. Over the years DMH has had many conversations with County Counsel and the Auditor-Controller about unlicensed facilities. They have raised some concerns including monitoring and quality of care issues. And yet, we know that many of our residents are living in these facilities. We do not know how many of these facilities would be willing to become licensed if certain impediments were removed, education and training of what it would entail to be licensed were provided or incentives were offered.

d. Trends

Concern about the relative fiscal health of the board and care system is not unique to Los Angeles County. In 2016, the CA Mental Health Planning Council initiated a statewide review of Residential Care Facilities in the state. They surveyed all 58 counties in CA, and 22 responded. (Los Angeles county was not one of the respondents.) The counties responded that 907 beds were needed, and 783 were lost over the past several years.[10] The respondents also indicated that in approximately 15 counties, beds had to be sought in another county because of the deficit in the home county.

According to the Planning Council, in their 2017 report, there were three main reasons why the shortage persists: (1) Financial; (2) Community Opposition, and (3) Staffing. Their data relative to the financial realities associated with running an adult residential facility will be described in greater detail below.

Another entity, the California Association of Local Behavioral Health Boards & Commissions, published an issue brief on ARF's in October, 2017 which outlined concerns about the "revolving

[9] It has been suggested that some licensed facilities are converting to unlicensed status. Such a facility may recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. However, less services are provided. It is hard to obtain details about specific locations, as these facilities prefer to remain "off radar."

[10] Source: CMHPC October 2017 report; page. 5.

door" when there are limited options for people coming out of acute in-patient treatment programs, transitional living or the correctional system.

In Los Angeles County, we assert that we are facing a crisis with respect to the survival of these precious housing resources. In just the past year, this ad-hoc commission received word that 11 board and care homes, ranging from 6 to 100+ beds, have closed, converted their operations or are considering closing. **This is just a small sample, pulled from our own network.** Examples of recent closures include:

- Brentwood Manor. This facility, located at 12311 West Santa Monica Blvd. was purchased in March, 2017 by a developer with the intention to transform it into a boutique hotel
- Western Ferndale Board and Care located at 1745 N. Western Avenue in Los Angeles
- Villa Poinsettia, 823 N. Poinsettia Pl, Los Angeles

These are facilities who have expressed concerns about their ability to continue their operations under the current scenario:

- Sunland Manor (approximately 100 beds), 10540 Sherman Grove Avenue, Sunland CA.
- Sepulveda Residential (approximately 80 beds). 8025 Sepulveda Blvd, Van Nuys, CA.
- Sharp Board & Care (6 beds), 10537 Sharp Avenue, Arleta, CA.
- Amigo Board & Care (two homes at 6 beds each), 8238 Amigo Avenue, Reseda and 23601 Vanowen, West Hills, CA.
- Blake Family Home (6 beds), 606 Jackman Street, Sylmar, CA.
- Alma Lodge (80 beds), 1750 Colorado Blvd, Eagle Rock, CA.
- Hartsook Board & Care (16 beds), 11045 Hartsook, North Hollywood, CA
- Golden State Lodge (14 beds), 11465 Gladstone Way, Lakeview Terrace, CA

Many of these have been in these neighborhoods for years. Owners who have run these businesses as family operations are now finding that the land is worth more that the business itself and are choosing to sell to developers. Not only are beds lost but opposition to opening other facilities in some of these communities proves insurmountable due to both the NIMBY mentality, changes in zoning and increased land and construction costs. Current board and care inventory ends up being used to re-house these displaced residents, further limiting options for homeless or new clients.

e. Financial Realities

With a reimbursement or rental rate of $35/day [11], a board and care operator is hard pressed to meet their obligations to provide the full array of services required under their licensing arrangement, with no relief in sight.

Further, the $134 that remains for the resident (from their social security disability check) must cover all their discretionary expenses including: clothing, transportation and travel, entertainment, cigarettes, and miscellaneous life expenses. This amounts to about $4 a day – a challenging amount for anyone to consider. This explains why residents of board and care homes, who don't have access to supplemental funding from family or friends, may resort to panhandling to make ends meet.

[11] As of January 1, 2018, the rates have changed ever so slightly. SSI rates for clients are $1037 plus $20 if they receive disability. Personal spending for incidentals is $134.

DMH has initiated two strategies for addressing the financial viability and program needs of Board & Care facilities.

1) Under Whole Person Care DMH is currently amending contracts with existing Community Care Residential Facilities for a $25 per day patch for clients that have been determined to have higher needs.

2) In addition, DMH will be releasing a Request for Applications (RFA) Specialized Supplemental Care Program (SSCP) in the spring 2018 to offer funding for augmented supports to all licensed adult residential facilities across the county. The RFA will allow DMH to augment the Basic Rate to fund additional staffing needed to serve individuals that have a serious mental illness and, due to their level of functioning, symptoms, and psychiatric history require service interventions that are in addition to or often more time-intensive to deliver than Basic Services. The payment of a supplemental rate will enable more placement options to individuals waiting to be transitioned from a higher level of care to the most appropriate residential setting based on their ability to function independently. The supplemental rate programs correspond to the level of service and/or staff. Funding will be offered for two different tiers of service: $25/day and $40/day.

Neither of these strategies has been fully implemented. And, as presented below, it is not clear that it will be enough. That is why it is essential that other community partners join in this effort.

The CA Mental Health Planning Council, in their October 2017 report presented a sample budget for a 13-resident facility. It documents in stark terms that the "rent" paid by residents does not even come close to covering the basic aspects of staffing, services and the facility costs. A break-even rent for this facility would require $2,805 per month. This budget is included as Table 1.

Table 1

**Residential Care Facility Sample Annual Budget (13 Person)**

| Title | Amount | Comment |
|---|---|---|
| **REVENUE** | | |
| **Resident Fees** | $160,056 | $1026/month for 13 residents at 95% occupancy |
| **Total Revenue** | **$160,056** | |
| | | |
| **EXPENSES** | | |
| **a. Personnel Expenses** | | |
| **Line Staff** | $182,000 | 4.5 Staff at $15/hour covers single coverage 7 days/week. Plus 1 FTE at 40 hours/week for administration/transport of clients to doctors, admissions, grocery shopping, etc at $20/hr |
| **Landscaping** | $2400 | $200/month |
| **Relief Staff** | $15,600 | Fill-in for sick/vacation employees at 20 hours/week |
| **Subtotal** | $200,000 | Presumes 9 sick days, 14 vacation days, 8 holidays/employee/year |
| **b. Salary Related Expenses** | | |
| **Health/Dental/Life/Vision Insurance (HSA)** | $39,600 | $600 month/employee, prorated for part-time for 5.5 employees. Rate is for minimal insurance. |
| **Unemployment Insurance** | $1,482 | |
| **Worker's Compensation Insurance** | $13,836 | |
| **FICA/Medicare** | $15,116 | |
| **Subtotal** | $70,034 | |
| **c. Other** | | |

| | | |
|---|---|---|
| **Training** | $2000 | |
| **Total Other Expenses** | $2000 | |
| **Total Personnel Expenses** | **$272,034** | |
| | | |
| **d. Operating Expenses** | | |
| **Legal and Other Consultation** | $1000 | |
| **Household Supplies** | $10,000 | Cleaning, paper supplies, non-food, any recreational supplies, linens, towels, paper goods |
| **Office Supplies** | $2,250 | |
| **Computer/Office Furnishings** | $1000 | |
| **Utilities** | $20,238 | |
| **Maintenance – Building and Equipment** | $12,000 | Presumes that this includes furniture and appliance replacement |
| **Vehicle Maintenance** | $6,000 | Presume one vehicle for use at $550/month |
| **Food** | $40,880 | $8 person/day plus one staff eating |
| **Insurance** | $8,215 | |
| **Telephone/Internet/Cable** | $3000 | |
| **Printing and Postage** | 500 | |
| **Licensing and Permits** | $1,711 | |
| **Property Taxes** | $6,000 | Presumes property purchased for $600,000 with $100,000 down payment |
| **Advertising** | 500 | |
| **Total Operating Expenses** | $113,294 | |
| **Rent or Loan Payments** | $30,396 | $500,000 loan for 30 years at 4.5% |
| **Total Expenses** | $415,724 | |
| **Total Net Income (Loss)** | **(255,668)** | (Revenue $160,056 minus Cost $415,724 = Loss $255,668) |

*Source: CA Mental Health Planning Council, October 2017 report, page 9.*

f. Case Studies

1. Golden State Lodge

In an example close to home, The Golden State Lodge, which has announced its intention to close, created a simple spreadsheet to document the fiscal strain that makes it impossible to operate without some additional source of funds. In this scenario, the assumptions are predicated upon a census that ranges between 10 to 13 guests per month. ***A break-even scenario would require a monthly rent of $2,500 per person.*** The full budget is included in the Appendix, but this abridged analysis documents the dilemma.

**Table 2**
**Golden State Lodge 2017 budget**

| Category | Amount | Total |
|---|---|---|
| **Revenue** | | |
| Resident rent | $ 122,100 | |
| Total revenue | | $ 122,100 |
| **Expenses** | | |
| **Administration** | | |
| Payroll | $ 123,954 | |
| Payroll taxes | $ 1,399 | |
| Workers comp | $ 11,515 | |
| Liability insurance | $ 9,757 | |
| Property insurance | $ 9,900 | |
| Employee insurance | $ 15,400 | |
| Property taxes | $ 17,600 | |
| Amortization | $ 41,800 | |
| Continuing education | $ 2,200 | |
| **Total admin** | | $ 233,525 |
| **Operations** | | |
| Food | $ 19,500 | |
| Utilities | $ 19,393 | |
| Repairs/mtce. | $ 10,700 | |
| Laundry | $ 2,750 | |
| Housekeeping | $ 3,300 | |
| Misc | $ 7,700 | |
| **Total operations** | | $ 63,343 |
| Total | | $ 296,868 |
| Profit/Loss | | $ (174,768) |

2. Villa Stanley

At the April 27, 2017 hearing of the County Mental Health Commission on the topic of the board and care system, Dr. Jay Plotzker, Administrator for two facilities, presented specific information about the costs of running the two facilities, the demographics of the residents and the needs.

His company runs two ARF's. Villa Stanley, licensed as an ARF in 1989, has 80 beds and is for non-ambulatory mentally ill clients. Villa Stanley East, licensed in 1999, has 62 beds. Residents are referred to Villa Stanley through social work personnel at area hospitals, families, social service agencies or DMH district offices.

**Table 3**
**Villa Stanley Census**

| | | |
|---|---|---|
| **Tenure of Residents** | Five years or more[12] | 50% |
| | One to five years | 30% |
| | Less than one year | 20% |
| **Gender** | Male | 80% |
| | Female | 20% |
| **Ethnicity** | Caucasian | 60% |
| | Hispanic | 10% |
| | African American | 22% |
| | Asian | 8% |
| **Age** | 18 – 35 years | 20% |
| | 35 – 60 years | 60% |
| | 60 and above | 20% |
| **Benefits** | MediCal and SSI only | 60% |
| | Medi-Medi SSI and SSA | 25% |
| | VA | 15% |
| **Ongoing Therapy** | Medi-Medi w/ PHP access | 7% |
| | Veterans w/ MHICM or DDTP | 5% |
| | FSP or Inter. Funding/DMH | 15% |
| | No ongoing therapy | 70% |

In his testimony to the Commission, Dr. Plotzger outlined the demands placed upon the facilities. His prime concern is financial. In his words: "The board and care is paid for all its services a total (SSI basic rate) of $1,026.37 per month. That works out to $33.74 per day. That is an absurd amount given all that we provide to care, support and assist clients."

Dr. Plotzger provided the Commission with some insight into the service demands placed upon the board and care operator. With respect to client care, they have to tend to their financial issues in resolving SSA, VA or family-related payments.

They must also tend to their client's mental health needs – emergency and routine – even for those who have no ongoing relationship with a service provider. Because no more than 30 percent of the residents are receiving therapy at any given time, there is a tremendous need for the remainder to have access to case managers, doctors, clinical therapists.

There is a lack of access to educational, vocational or life-skills education. Particularly for younger residents, who might have an opportunity to wean themselves off government support, there is no support for vocational training.

They must tend to the routine and emergency maintenance needs of their facilities and be responsive to licensing requirements. They also have to stay connected with the community, to address the issues that typically come up in the neighborhood.

[12] According to Dr. Plotzker, some have lived at Villa Stanley for up to 20 years.

The reimbursement does not keep up with inflation. For example, he reports, the cumulative Consumer Price Index (CPI) for the LA area, since 2010, was 11.4%. Since 2010, the cumulative SSI/SSP increase has been only 6.4%. He suggested that with even a $5 or $10 per resident, per day increase, "there is much that we can do."

The future financial picture looks bleak. He expressed concern about the mandated increased in the minimum wage, and how that will impact their ability to comply with mandatory staffing of an ARF, as per Community Care Licensing guidelines. He anticipates increases in the cost of food, and related staffing costs related to preparation. He foresees increasing insurance costs (liability and medical) as well as Worker's Compensation. And finally, there is the ongoing costs associated with building repairs and maintenance. His facilities (as is the case with many others in the county) are aging and there are limited funds to handle capital improvements. He cited an example whereby two years ago, he had to pay $50,000 to replace an elevator.

In sum, if this system were funded more adequately, he suggested that the clients would have access to more therapy and services, activities, better food and nicer surroundings.

g. Quality of Facilities

This Ad-Hoc committee has limited its focus, for the most part to the financial issues facing board and care facilities and the critical need to stop the loss of these types of beds. There remains a real issue about the quality of life of those who live at facilities. Many of these facilities are run down and have multiple deferred maintenance needs. Owners will say that the money doesn't exist for them to do needed repairs, much less improve the cosmetic appearance of these facilities.

Financial pressures prevent most of these facilities from also providing any type of programming, therapeutic or otherwise. Many residents spend their days with little to do. Ironically, DMH and facilities have had to be careful in what they offer because of concerns of triggering the Federal IMD Exclusion. The exclusion prohibits Federal Financial Participation funds from being drawn down for mental health services if an owner of a facility is also the service provider on the site. That being said, DMH has developed some innovative programs such as the enriched residential facilities that enable providers to comply with regulations while offering treatment to clients, albeit at a nearby clinic site. We would argue that more can be done in this realm and hope that it will remain a topic of concern and focus.

## III. CALL TO ACTION

First, it is important the county make a commitment to data collection to understand the trends relative to beds available for people with mental illness. The housing shortage is at a crisis level in L.A. County, and it is important to track this inventory to understand gaps and needs. The data collection, at the very least should:

- Identify the current inventory of ARF beds available for people living with serious mental illness today, and compare, to the extent possible, how the inventory has changed over the last one to five years;
- Identify the extent to which beds lost over the last one to five years have disappeared due to:
    - Conversion to another demographic group which offers greater subsidy
    - Conversion to unlicensed status
    - Sale of property for another use
    - Closure of home
- Identify if any new facilities have come on line in the last one to five years

Second, a sustainable commitment to enhanced funding needs to be identified to forestall additional shutdowns and to enhance quality of life for individuals living in these homes. It is estimated that "patches" or subsidies ranging from $64/day to $125/day (according to the CMHPC) would be necessary to maintain fiscal viability.[13] This will require more than just what is currently proposed for patches by DMH and other community partners must step in. The county should conduct an audit of ARF's of various sizes to ascertain what the extent of that patch would be in L.A. County to protect this housing inventory.

Third, it is recommended that policy makers who analyze housing supply and demand in Los Angeles County include Adult Residential Facilities in the continuum of community-based housing available for people with serious mental illness, as well as formerly homeless individuals. Arguably, formerly homeless residents with serious mental illness are more vulnerable than those targeted for permanent supportive housing with services attached. Surprisingly, under federal rules for defining "chronic homelessness," people leaving institutions are often not considered eligible for permanent supportive housing.

Fourth, in addition to shoring up the financial viability of board and care homes, it is critical to look beyond just the "brick and mortar" sustainability of these facilities and aspire to investing in opportunities for an enhance quality of life for those who live within this system. Patches above and beyond what is necessary to mitigate against closure will be required to invest in critical human needs including transportation of residents, linkage to day-time services and activities, and training for staff. Enrichment opportunities may also be generated by linkages to community services, adult schools, churches and volunteers, and this will require staffing and coordination.

Fifth, the Department of Mental Health should commit to a formalized liaison relationship with the board and care operators in order to provide support, training and an opportunity to dialogue about needs and aspirations.

Sixth, the county should identify a liaison with the California Mental Health Planning Council who has embraced this issue as a critical priority. The CMHPC has identified some state-level solutions that may require county policy support. Included in those recommendations is consideration for a "tiered level of

[13] This recommendation is echoed by the CA Assoc. of Local Behavioral Health Board & Commission's report that indicates a patch of $64 to $125/day is needed to sustain operations for facilities >45 beds.

care system" which would allow for different levels of reimbursement based upon resident needs (similar to what is done for residents with developmental disabilities.) The Planning Council has also recommended advocating for a higher State Supplemental Payment (SSP) rate.

**Kathy Jones**

**From:** Canetana Hurd
**Sent:** Monday, January 29, 2018 2:56 PM
**Subject:** FW: Ad Hoc Committee report on Board and Cares
**Attachments:** Report to LACMH Commission re BoardCare draft 3.pdf

Sent on behalf of Commissioner Weissman

Greetings Commissioners,

This is a reminder -- commissioners are welcomed to submit written feedback to me on the Board and Care's report presented by Caroline Kelly at the January 25 Commission meeting. Please provide feedback as soon as possible.

Brittney Weissman
(818) 687-1657
Brittney@namilaccc.org

On Jan 22, 2018, at 12:09 PM, Canetana Hurd <CHurd@dmh.lacounty.gov> wrote:

Sent on behalf of Caroline Kelly

Dear Commissioners,

At the January 25th meeting, the ad hoc committee on Board and Care facilities will ask the commission to approve our draft, subject to additional editing (for better formatting, not substantial changes in content). We are looking for the commission to approve this so that we can begin reaching out to different groups to seek funding and partnerships.

As of right now, the ad hoc committee, through its member, Kerry Morrison has requested to be on the agenda of the next HHH meeting on February 16th. We will be asking the HHH group to consider either providing patches or looking into the purchase of board and cares that will be closing. We hope to finalize our draft to present to this group. I will be present to answer questions about the report at this time. The last segment of our report includes the specific recommendations to the Department and the Board. As you will see, most focus on the department doing more as far as inventory and looking at potential funding models.

If you do not feel you can fully approve the report, we hope that you can make specific recommendations for us to consider for incorporation, we can call an ad hoc committee conference call and we can seek final approval at the executive committee meeting, as long as commissioners approved that the executive committee could approve it subject to certain changes. For reasons of Brown Act, we can't discuss this report as a whole body via e-mail but if you have specific suggestions to incorporate before Thursday, please do e-mail me directly.

Thanks,

Caroline

**Caroline Kelly, JD**
Consultant for Systems Redesign, Office of the Director
CaKelly@dmh.lacounty.gov
Direct line: 310 804-2610

<Report to LACMH Commission re BoardCare draft 3.docx>

<Mail Attachment.eml>

CITY OF LOS ANGELES
CALIFORNIA

Richard H. Llewellyn, Jr.
INTERIM
CITY ADMINISTRATIVE
OFFICER

ASSISTANT
CITY ADMINISTRATIVE OFFICERS
PATRICIA J. HUBER
BEN CEJA
YOLANDA CHAVEZ

ERIC GARCETTI
MAYOR

# Proposition HHH
# Citizens Oversight Committee (COC)

**Friday, February 16, 2018**
**2:00 PM**
**City Hall, Room 1010, 10th Floor**
**200 N. Spring Street**
**Los Angeles, CA 90012**

**MEMBERS**

Miguel Santana, Chair
Tunua Thrash-Ntuk, Vice Chair
Blair Besten
Tiffany Boyd
Nicholas Halaris
Kerry Morrison
Amelia Williamson

**AGENDA**

1. General Public Comment, Multiple Agenda Item Comment
2. Approval of Minutes for January 19, 2018 COC meeting
3. Update on Proposition HHH Fiscal Year 2017-18 Housing and Facilities Program – *Verbal update from the City Administrative Officer and Housing and Community Investment Department*
4. Update on Permanent Supportive Housing Ordinance and Interim Motel Conversion Ordinance *Verbal report from the City Administrative Officer*
5. Temporary Structures Working Group - *Verbal report from the City Administrative Officer*
6. Board & Care Facilities – Potential Conversion to Permanent Supportive Housing (PSH) - *Presentation by Kerry Morrison, Member of Prop HHH COC and Los Angeles County Mental Health Commission Ad-Hoc Subcommittee*
7. United Way of Greater Los Angeles "Everyone In" Supportive Housing Siting Campaign - *Presentation from the United Way of Greater Los Angeles*

8. Future Agenda Items
    a. March 2018 meeting
        i. Prop HHH Fiscal Year 2018-19 Project Expenditure Plan (PEP) for the Permanent Supportive Housing Loan Program and Facilities Program
        ii. Standardized and pre-approved design practices for PSH
    b. April 2018 meeting
        i. HCID Prop HHH PSH Loan Program Round 2 Call For Projects Commitments
        ii. HCID Updates to Prop HHH Fiscal Year 2018-19 Project Expenditure Plan (PEP)
        iii. Quarterly Prop HHH FY 2017-18 Bond Status Report
    c. Other Items
        i. New State funding sources and leveraging opportunities
        ii. State of California No Place Like Home Program
        iii. Engagement of sub-populations within the Homeless Community
        iv. Continued discussion of shared housing
        v. Continued presentations on housing innovation
        vi. HCID plan for Prop HHH Unit Production
        vii. SB 827 and the Housing Accountability Act
        viii. Expanding the pool of developers through partnerships with established and emerging developers
        ix. Housing Finance 101 – Housing and Community Investment Department

9. Adjournment

**GENERAL INFORMATION**
For information regarding the COC and its operations, please contact Elyse Matson Azevedo at (213) 473-7460. This contact may answer questions and provide materials and notice of matters scheduled before the COC.

**NOTIFICATIONS & MATERIALS**
To receive meeting notices for the COC, subscribe through the Early Notification System at www.lacity.org. Materials related to items on this Agenda will be posted to the City Administrative Officer's website at http://cao.lacity.org/Homeless/index.htm.

**PUBLIC COMMENT**
Members of the public are invited to provide general comments related to matters in the COC's jurisdiction, and/or comment on any particular Agenda item. Unless otherwise specified in this Agenda, an opportunity for the public to provide general comments and/or comments on specific Agenda items will be provided during the General Public Comment/Multiple Agenda Item Comment period, prior to action by the COC on any specific Agenda item. Members of the public who wish to speak on items shall be allowed to speak for up to one minute per item, up to a total of three minutes, per meeting.

**SERVICES/REASONABLE ACCOMMODATIONS**
Upon request, COC staff will provide reasonable accommodations to enable individuals with disabilities to participate in its meetings, including access to Agenda materials in alternate formats, sign language interpreters, assistive listening devices or other auxiliary aids, or other services. If you have such a request, please contact Elyse Matson Azevedo at (213) 473-7460 at least 72 hours prior to the COC meeting to ensure availability. Due to difficulties in securing sign language interpreters, five or more business days' notice is strongly recommended.

**CLOSED SESSION**
The COC may meet in Closed Session on any subject permitted by law for Closed Session purposes.

**City of Los Angeles**
**Proposition HHH**
**Citizens Oversight Committee (COC)**
**Minutes for the meeting held on:**
**Friday, January 19, 2018**
**2:00 PM**

**COC members in attendance:**

Miguel Santana, Chair
Tunua Thrash-Ntuk, Vice Chair
Blair Besten
Kerry Morrison
Amelia Williamson
Tiffany Boyd

The meeting was called to order at 2:15 p.m. by Miguel Santana, Chair.

1. **General Public Comment, Multiple Agenda Item Comment**
   Public Comment was heard from 17 speakers:
   Mike Bonin
   Stella L. Anna Nunez
   Armando Herman
   Goat Puppet
   Gerald Gabatan
   Bill Tavelli
   William Williamson
   Monte Williams
   Mary Shepard
   Ayjia Flowers
   Jose Pina
   Godfrey Waclira
   Kendall Walker
   Ayahsham Gethrew
   Tod Lipka
   Noreen McClendon
   Jesse Creed

2. **Approval of Minutes for November 17, 2017 COC meeting**
   - The minutes were approved without objection.

3. **Proposed Schedule for FY 2018-19 Bond Issuance**
   - Presentation by Meg Barclay, City Homeless Coordinator.

4. **First Proposition HHH FY 2017-18 Bond Status Report**
   - Presentation by Meg Barclay, City Homeless Coordinator and Tim Elliot, Housing and Community Investment Department (HCID).
   - The COC considered and forwarded the report to the Proposition HHH Administrative Oversight Committee (AOC) for review.

5. **Proposition HHH Permanent Supportive Housing Loan Program Commitments – Round 1 Call for Projects**
    - Presentation by Sean Spear, Tim Elliot, and Rushmore Cervantes, HCID.
    - The COC considered and forwarded the report to the AOC with the following proposed recommendations:

A. That the AOC recommend that the Council authorize HCID to issue letters of commitment as outlined in the attached report; and,
B. That the AOC amend the report to add the following four (4) projects, which HCID did not recommended for letters of commitment, subject to these projects satisfying the Round 1 Call for Projects requirements prior to Council consideration of this report:

1. West Third Apartments (CD 1);
2. Western Avenue Apartments (CD 8);
3. Building 205 (CD 11); and
4. Building 208 (CD 11).

6. **Affordable Housing and Sustainable Communities (AHSC) Program Applications**
    - Presentation by Sean Spear, HCID.
    - No action was required on this item.

7. **Impact of Federal Tax Reform on Proposition HHH Permanent Supportive Housing Loan Program Financing**
    - Presentation by Sean Spear, HCID.
    - No action was required on this item.

8. **Future Agenda Items**
    a. March 2018 meeting
        i. Prop HHH Fiscal Year 2018-19 Project Expenditure Plan (PEP) for the Permanent Supportive Housing Loan Program and Facilities Program
        ii. Standardized and pre-approved design practices for PSH
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        iv. Continued discussion of shared housing
        v. Continued presentations on housing innovation
        vi. HCID plan for Prop HHH Unit Production

vii. SB 827 and the Housing Accountability Act
viii. Expanding the pool of developers through partnerships with established and emerging developers
ix. Housing Finance 101 – Housing and Community Investment Department

**9. Adjournment – Meeting was adjourned at 4:42 p.m.**

**Kathy Jones**

**From:** Brittney Weissman <brittney@namilaccc.org>
**Sent:** Monday, January 29, 2018 1:56 PM
**To:** Canetana Hurd
**Subject:** Re: Ad Hoc Committee report on Board and Cares

Hi — Hmmm. That attachment didn't open properly so I don't know what was in it and can't access the roster. I only wanted to remind the commission that if they have any comments on the Board and Care report, to get that to me ASAP. Can you please forward that message?

Thank you!
Brittney

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
3250 Wilshire Boulevard, Suite 1501
Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
http://secure-web.cisco.com/1w246GiN5c7tPHeP_MzsgkIJ7jFpeBjPewUjBXtvDcQesm5Vthl077zJMKfRvUkByUb0gkpWNr_zeCgkvAP_0K8BMga6TYMNFIPP2BZ54uQrH7fIb_hCzN7CynFgEi_HtxbOEv7BlsWRU5v8wRXa9mkgBEh-XqUFHFLObB-h5lx4SVigsugfEZxRRPXIwX8bc9K02fAe3IuM-UBOIrMSl6iVI4i9FRLC8tEoW11N1mVmom7r88O-h_FmnZzBLQlNmlxlNBF0TCALJGJYwytCvdoMutFEMYkYt17U26c6JGeYnf5dTFLfV1-T9j4V61b4qZy4LVPmdomumRaPqoqQJrWT_xFbiCxcrV-DeAthxly1EXTwky2CjhF3S97sBNVxH/http%3A%2F%2Fwww.namilacc.org
www.facebook.com/NAMILACC.org

National Alliance on Mental Illness | Los Angeles County Council

On Jan 29, 2018, at 10:00 AM, Canetana Hurd <CHurd@dmh.lacounty.gov> wrote:

Hi Brittney,
Send me the notice and I will email to commissioners on your behalf. Or you are welcome to use the commission distribution list (see attached).

---

**From:** Brittney Weissman [mailto:brittney@namilaccc.org]
**Sent:** Sunday, January 28, 2018 2:59 PM
**To:** Canetana Hurd; lawrencejlue@gmail.com
**Cc:** Caroline Kelly
**Subject:** Re: Ad Hoc Committee report on Board and Cares

Hi Canetana - I'm not sure how follow up from these MHC meetings work, but I would like to send notice out to remind the commissioners to summit written feedback to me on this report as soon as they can, if they have any.

Thanks,
Brittney

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
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Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
http://secure-web.cisco.com/1gPOwG9xzK3ZLfc9EATJHrLIiKlVsan6vqDSA6bogir-F0ZAfBCDYYtsuKNBDOaBdt2flZJ1QP7eVldiViguWWAyTUK8Y6Q6lUx_BLWlvbMoP3iLY5Yk3euthyY7WCJ-pzntjKhXdXlY6rF_bTWDBEN8lj95SpZggk-6ycUbF2aVl4p8wStZFEWv-4dVcOHRzwvfRUL6L2VcbP9koT46DBZTexab8M6u_tuJaUoOlG7rwGVuE5WwrnEofdcOtz0qW_woPPEAeS_Yn0YWUDN2ztIedEk9dnoLYVplCNgce71avnYj3FWrJwQGPAi6-HHp-5QB_8WoPOaSWaWQuPxbKxiVujmMe9gWTTwFrvW3ZHRy96PthZcfzkW6m0fscCyqC/http%3A%2F%2Fwww.namilacc.org
www.facebook.com/NAMILACC.org

<image001.jpg>

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Consultant for Systems Redesign, Office of the Director
CaKelly@dmh.lacounty.gov
Direct line: 310 804-2610

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http://secure-web.cisco.com/1gPOwG9xzK3ZLfc9EATJHrLliKlVsan6vqDSA6bogir-F0ZAfBCDYYtsuKNBDOaBdt2flZJ1QP7eVldiViguWWAyTUK8Y6Q6IUx_BLWlvbMoP3iLY5Yk3euthyY7WCJ-pzntjKhXdXlY6rF_bTWDBEN8lj95SpZggk-6ycUbF2aVl4p8wStZFEWv-4dVcOHRzwvfRUL6L2VcbP9koT46DBZTexab8M6u_tuJaUoOlG7rwGVuE5WwrnEofdcOtz0qW_woPPEAeS_Yn0YWUDN2ztledEk9dnoLYVplCNgce71avnYj3FWrJwQGPAi6-HHp-5QB_8WoPOaSWaWQuPxbKxiVujmMe9gWTTwFrvW3ZHRy96PthZcfzkW6m0fscCyqC/http%3A%2F%2Fwww.namilacc.org
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NAMI Los Angeles County Council
National Alliance on Mental Illness

On Jan 22, 2018, at 12:09 PM, Canetana Hurd <CHurd@dmh.lacounty.gov> wrote:

Sent on behalf of Caroline Kelly

Dear Commissioners,

At the January 25th meeting, the ad hoc committee on Board and Care facilities will ask the commission to approve our draft, subject to additional editing (for better formatting, not substantial changes in content). We are looking for the commission to approve this so that we can begin reaching out to different groups to seek funding and partnerships.

As of right now, the ad hoc committee, through its member, Kerry Morrison has requested to be on the agenda of the next HHH meeting on February 16th. We will be asking the HHH group to consider either providing patches or looking into the purchase of board and cares that will be closing. We hope to finalize our draft to present to this group. I will be

present to answer questions about the report at this time. The last segment of our report includes the specific recommendations to the Department and the Board. As you will see, most focus on the department doing more as far as inventory and looking at potential funding models.

If you do not feel you can fully approve the report, we hope that you can make specific recommendations for us to consider for incorporation, we can call an ad hoc committee conference call and we can seek final approval at the executive committee meeting, as long as commissioners approved that the executive committee could approve it subject to certain changes. For reasons of Brown Act, we can't discuss this report as a whole body via e-mail but if you have specific suggestions to incorporate before Thursday, please do e-mail me directly.

Thanks,

Caroline

**Caroline Kelly, JD**
Consultant for Systems Redesign, Office of the Director
CaKelly@dmh.lacounty.gov
Direct line: 310 804-2610

<Report to LACMH Commission re BoardCare draft 3.docx>

## Kathy Jones

**From:** Caroline Kelly
**Sent:** Monday, January 22, 2018 11:47 AM
**To:** Canetana Hurd;lawrencejlue@gmail.com;Kerry Morrison;barbarawilsonlcsw@gmail.com
**Subject:** Ad Hoc Committee report on Board and Cares

Please forward this to the full commission today with the following message.
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**Caroline Kelly, JD**
Consultant for Systems Redesign, Office of the Director
CaKelly@dmh.lacounty.gov
Direct line: 310 804-2610

## Kathy Jones

**From:** Caroline Kelly
**Sent:** Monday, January 22, 2018 12:03 PM
**To:** Canetana Hurd
**Subject:** RE: Ad Hoc Committee report on Board and Cares
**Attachments:** Report to LACMH Commission re BoardCare draft 3.docx

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**From:** Canetana Hurd
**Sent:** Monday, January 22, 2018 11:56 AM
**To:** Caroline Kelly <CaKelly@dmh.lacounty.gov>
**Subject:** RE: Ad Hoc Committee report on Board and Cares

No attachment?

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**From:** Caroline Kelly
**Sent:** Monday, January 22, 2018 11:47 AM
**To:** Canetana Hurd; lawrencejlue@gmail.com; Kerry Morrison; barbarawilsonlcsw@gmail.com
**Subject:** Ad Hoc Committee report on Board and Cares

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Thanks,

Caroline

**Caroline Kelly, JD**
Consultant for Systems Redesign, Office of the Director
CaKelly@dmh.lacounty.gov
Direct line: 310 804-2610

**Kathy Jones**

**From:** Brittney Weissman <brittney@namilaccc.org>
**Sent:** Monday, October 16, 2017 11:38 AM
**To:** Kerry Morrison;Mary Marx
**Cc:** Caroline Kelly;barbarabwilsonlcsw@gmail.com;Canetana Hurd
**Subject:** Re: Conference call - 888 204 5987 #9639884
**Attachments:** Standard of Care for the Mentally Ill 040417.pdf; Report Back Standard of Care for Mentally Ill 091817.pdf

Here're the reports to which I'm referring regarding tomorrow's BOS meeting.

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
3250 Wilshire Boulevard, Suite 1501
Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
http://secure-web.cisco.com/1321Kq6xl9Oj2Pe6gBRiwN6QNIZHK3UpXx3GR4Rqy479wdg4Yu0Ac-uhW7DuYUPUJViDyhkFYIYp2pw6DR6mzcQTHoYBcdWWd4vUsJbh4caBHL1Z-iO3K3tkpr6LOIM4qWBVAXjK8HuiuIB8JhAEp_EdPgE8-hshF4UwqsKUpJbSYWEMRP-m9Ux5vK0HtcAZ6ojmXerFcUC5qAmwuQdV5Rjc8zyYxuc1hKU6KO_MzwROO-_7jHMsdf9ejSE1PQdxVhHU_gITGPVpzOFgKDl1sFHeA4N65OSCWEO9T9aX48OepTFHqiD565FVOMtqJauBnG8UNdh-dfM_IGeW-UK2PYzF6gWKziWGi9rJDrCAGqZbcqjMpcLq9XVrfOcDhZGITm6oPWMKAxeujfFGtekOj2A/http%3A%2F%2Fwww.namilacc.org
www.facebook.com/NAMILACC.org

On Oct 16, 2017, at 11:20 AM, Kerry Morrison <kerry@hollywoodbid.org> wrote:

Caroline, we are on a different number. Call here

641-715-3620

960217
Sent using OWA for iPad

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**From:** Caroline Kelly <chairlamhc@gmail.com>
**Sent:** Monday, October 16, 2017 11:18:47 AM

**To:** Kerry Morrison; barbarabwilsonlcsw@gmail.com; brittney@namilaccc.org; Cy Cantena Hurd
**Subject:** Fwd: Conference call - 888 204 5987 #9639884

Are we all calling this number?

Sent from my iPhone

Begin forwarded message:

> **From:** Barbara B Wilson <batnp@hotmail.com>
> **Date:** October 13, 2017 at 8:23:43 PM PDT
> **To:** "brittneyweissman@gmail.com" <brittneyweissman@gmail.com>, Mary Marx <MMarx@dmh.lacounty.gov>, Gilda Ramos <GRamos@dmh.lacounty.gov>, "kerry@hollywoodbid.org" <kerry@hollywoodbid.org>, Brittney Weissman <brittney@namilaccc.org>, Commissioner Kelly <ChairLAMHC@gmail.com>
> **Subject: Conference call - 888 204 5987 #9639884**

AGN. NO._____

MOTION BY SUPERVISOR KATHRYN BARGER April 4, 2017

**Standard of Care for the Mentally Ill**

On March 7, 2017, Los Angeles County residents passed Measure H; a quarter cent sales tax over a ten year period to provide essential resources to address the County's homeless crisis. The passage of this measure is a tremendous step forward in the County's fight against homelessness.

The most challenging obstacle that the County faces over the next ten years is the issue of chronic homelessness. Chronic homelessness is the face of the County's homelessness crisis. The term "chronic" attaches a distinct definition to homelessness, involving either long-term and/or repeated bouts of homelessness coupled with a physical and/or mental disability. Those that are chronically homeless are our most vulnerable population in need of treatment and care.

Within the County's chronically homeless population there is a significant segment of individuals that refuse any kind of treatment and/or care. Although they refuse care, it is apparent that they are in desperate need of treatment and unable to make a conscious decision to seek or accept proper treatment and provide for basic personal needs (such as food, clothing, and shelter). This presents a significant truth; he or she is a danger to themselves.

Section 5150 of the California Welfare and Institutions Code authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes him or her a danger to him-or herself, a danger to others, and/or is *gravely disabled*. The hold duration is allotted for up to a 72 hour period, a time span in which it

MOTION

Solis _____

Kuehl _____

Hahn _____

Barger _____

Ridley-Thomas _____

is impossible to provide meaningful treatment to someone that is facing severe mental disability. After a 72 hour hold the individual is back on the streets and concludes that treatment is ineffective thus, increasing their resistance to treatment in the future. This treatment option is, in many cases, vastly insufficient.

The lack of mental healthcare beyond a temporary emergency hold has been realized in other states as well. For example, in early 2014, Virginia State Senator Creigh Deeds (D-Bath) introduced legislation to address the lack of treatment beyond an emergency temporary hold. Virginia Senate Bill 260 directed the Department of Behavioral Health and Developmental Services to establish an acute psychiatric bed registry that provides real-time information on the availability of beds in public and private psychiatric facilities and residential crisis stabilization units for individuals who meet the criteria for temporary hold and are in need of extended care. This legislation was authored by Senator Deeds after his son committed suicide following his release from a temporary emergency hold order. Virginia's SB 260 ultimately passed and was signed into law by the Governor.

There needs to be a higher standard of mental healthcare. With a short ten year window to address homelessness using Measure H funds, the County must review and revisit the application of California Lanterman-Petris-Short Act to ensure that we have requisite authority to provide care for those who are suffering from mental illness and are unwilling and/or incapable of accepting care.

**I, THEREFORE, MOVE** that the Board of Supervisors direct County Counsel to work with the Department of Mental Health to provide a legal analysis, interpretation, and application of all existing State Mental Health Laws, along with recommendations on ways the County can achieve requisite authority to provide humane treatment for those who are suffering from mental illness and are unwilling and/or incapable of accepting care. The analysis should include recommendations for amendments to existing laws, if necessary, and report back in 45 days.

# # #

KB:EM

**LOS ANGELES COUNTY**
**DEPARTMENT OF MENTAL HEALTH**

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

September 18, 2017

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

Mary C. Wickham
County Counsel

SUBJECT: **STANDARD OF CARE FOR MENTALLY ILL (ITEM NO. 5, AGENDA OF APRIL 4, 2017)**

On April 4, 2017, your Board instructed the Department of Mental Health (DMH) in collaboration with County Counsel and other relevant departments to analyze existing State mental health laws and provide recommendations for the humane treatment of people living with mental illness and who are unwilling or incapable of accepting care. Additionally, you asked us to address potential risks to civil liberties if our recommendations triggered them and to assess the potential expansion of necessary mental health resources and housing based on current and future funding streams.

Our departments established a working group to address these issues and to develop recommendations. As part of this process, DMH convened a symposium with a full range of County and community stakeholders to specifically address approaches to engaging and delivering mental health services to chronically homeless populations suffering from serious mental illness. This symposium served as a springboard to review and revisit the application of the Lanterman-Petris-Short (LPS) Act and other related laws to empower the County to better care for this vulnerable population.

As part of an ongoing collaborative effort, the work group's recommendations were shared, developed, and discussed with these stakeholders. This final set of recommendations is a direct product of this collaboration which furthers the collective goal of humanely caring for homeless persons with mental illness.

This report back sets forth a list of recommendations to humanely treat those suffering from mental illness. Most recommendations are supported by existing law; only one requires legislative change. Each recommendation focuses on the engagement, care, and sustainability of care for those in need of involuntary mental health treatment services without infringing upon the civil liberties of those individuals.

**BACKGROUND**

State and federal law recognizes that every adult with the capacity to make health care decisions has the fundamental right of self-determination over his or her body. While every competent individual has the Constitutional right to refuse any medical treatment, courts have consistently held that this right is not absolute and must yield to compelling State interests. Such interests include the protection of public health and safety from those who present a danger to themselves or others, as well as the protection of persons who cannot care for themselves.

In California, the principal law governing mental health evaluation and treatment is the LPS Act (Welfare and Institutions Code (WIC), § 5000 et seq.). The law sets forth the procedures that law enforcement and health care providers must follow to detain a person for involuntary mental health evaluation and treatment as well as assignment of a surrogate decision-maker. Its purpose is to provide prompt, incremental treatment to persons with mental disorders, to protect public safety, and to safeguard the rights of such persons through judicial review.

We discuss our recommendations and rationales in the context of the key areas of the LPS Act, including the need for resources and housing, through identified funding streams, where applicable. These recommendations address issues relating to detention and conservatorship criteria, transportation, as well as increased access to care.

**DISCUSSION/RECOMMENDATIONS**

I. <u>LPS Detentions and Conservatorship for Involuntary Treatment Due to Mental Illness</u>

Under the LPS Act, persons who pose a danger to self, pose a danger to others, or are gravely disabled may be detained for varying periods of time in designated mental health facilities for involuntary evaluation and treatment. A person is gravely disabled when he or she is unable to provide food, clothing, or shelter for him or herself due to his or her mental disorder and cannot or will not agree to voluntary treatment. The detention period, also referred to as a *hold*, usually depends on the nature and duration of the person's illness and is subject to judicial review. Typically, such persons are initially detained by first responders or health care

professionals for up to 72 hours, pursuant to WIC § 5150. This 72-hour period is commonly referred to as a *5150 hold*. Persons may be detained for an additional 14-day period for intensive treatment. For persons who present an imminent threat of suicide during the 14-day period or 72-hour evaluation period, a second 14-day period for such treatment may be authorized.

If at the end of the first 14-day hold, the person continues to be in need of care due to a grave disability, an additional 30-day period of intensive treatment may be authorized or a petition for temporary conservatorship may be filed with the court. If a temporary conservatorship is granted, it lasts a maximum of 30 days and must run concurrently with the 30-day period for intensive treatment because a gravely disabled person may not be held involuntarily for more than a total of 47 days from the initial 72-hour hold.

LPS conservatorship is a process in which the court appoints a conservator to manage a conservatee's mental health treatment, including placement and medication. At any time during an LPS hold for evaluation and treatment, if a person is considered to be gravely disabled, a treating physician may recommend the public guardian petition the court to establish a conservatorship over the person. The proposed conservatee has the right to a jury trial, and the jury's determination of gravely disabled must be unanimous and beyond a reasonable doubt. If granted, the conservatorship lasts for a period of one year, and the conservator may petition the court for reappointment each year. During the conservatorship period, the conservatee has the right to request the court rehear the conservatorship decision once every six months.

Although the public guardian must recommend the most suitable person, corporation, or other public or private agency, the court has the sole discretion in appointing the conservator. In making the selection, the court is guided by the best interests of the proposed conservatee, the public guardian's recommendation, and the statutory order of preference when there is more than one conservator recommended. If there is no suitable person or entity willing or able to serve as conservator, the court will appoint the public guardian as conservator. Once appointed, the conservator will have the legal power to make decisions regarding placement and to require the conservatee to receive mental health treatment and psychotropic medications as indicated.

Our analysis of the LPS Act and interaction with stakeholders affirms that a lack of treatment for persons with serious mental illness may result in chronic homelessness and instability for those persons. These recommendations address ways to interrupt the cycle of homelessness through the engagement and care of

those in need of mental health treatment to ensure consistent, lasting care in the least restrictive and most stable placements.

**Recommendation 1**
**Ensure accurate and consistent interpretation of the proper basis for finding probable cause for grave disability, danger to self, and danger to others for purposes of detention and establish a robust, consistent training for first responders and clinicians based.**

This recommendation addresses the lack of consistency among first responders, clinicians, and others in determining when to detain persons under the LPS Act. The development of an accurate and consistent interpretation of causes for involuntary detention under the LPS Act will improve access to care. County Counsel, DMH, and Public Guardian can take the lead in this effort. Developing this interpretation can be combined with robust training of first responders and clinicians to consistently assess for the presence of probable cause for detention by finding danger to self, danger to others, or grave disability. Persons deteriorating as a result of their inability to care for their physical health could be considered a danger to self as well as gravely disabled. A key aspect of such training should be more comprehensive assessment of danger or disability resulting from potential or actual deterioration of an individual's condition due to medical or behavioral issues over time, especially under the initial involuntary holds. The training will include consideration of non-imminent harm factors as well as data collection reflecting the historical course of a person's mental disorder. A checklist with concrete elements may be utilized to further ensure consistency.

Such training can be developed through DMH with the Office of the Medical Director, the Public Guardian, and the Office of Patients' Rights. Resources for such efforts may come from a variety of sources, including Mental Health Services Act (MHSA) funding.

**Recommendation 2**
**Transition current Psychiatric Mobile Response Team (PMRT) operations, practice, and policy to grow DMH's real time mobile response capacity in the context of acute and urgent scenarios by: 1) increasing the number of active vehicles as well as personnel (clinician and peer teams) deployed to each Service Area, and 2) expanding the range of activities delivered by each mobile team to include not only outreach and hospitalization under 5150 detention but also real time engagement and triage (with transportation as indicated) for clients needing shelter, respite and/or treatment otherwise.**

This recommendation addresses a need for proactive engagement and triage that is better tailored, more humane, timely, cost effective, and efficient with an increased reliance on services and non-inpatient care settings such as Urgent Care Centers (UCC), Crisis Residential Treatment Programs, and other treatment and residential resources.

The need for ambulance and law enforcement assistance, critical in certain scenarios, will be determined in the field by PMRT teams who can leverage these specialized services more selectively as indicated by clinical demand. DMH will utilize MHSA funding for additional clinicians and vehicles needed to implement this recommendation.

**Recommendation 3**
**Develop guidelines and outreach programs for law enforcement assistance when DMH crisis teams (PMRT) determine the presence of probable cause for a 5150 hold of individuals who resist assessment or transport to an LPS designated facility.**

This recommendation addresses the need to engage and assist persons who are resistant or assaultive but in need of hospitalization. Law enforcement may hesitate to physically restrain such persons due to concerns about preserving the individual's civil rights and the reasonable basis for restraint. Absent assistance by personnel trained and equipped to detain and transport individuals who are likely to physically resist or who are potentially assaultive, DMH teams are forced to leave such people in the field even though they meet criteria for detention under section 5150. This restricts access to care and heightens the risk of harm to both the community and those not detained. Under collaboratively developed guidelines, DMH and County Counsel will work with law enforcement to coordinate efforts responding to such situations.

**Recommendation 4**
**Develop consistency among LPS designated facilities and their medical staffs in submitting referrals for conservatorship.**

This recommendation addresses the lack of consistency among various LPS designated facilities in determining when to refer a person to the Public Guardian for LPS conservatorship. Such consistency is expected to ensure greater access to care by promoting the congruous application of LPS referral practices among LPS designated facilities. DMH will review the practices of these facilities to identify any differences in their conservatorship referral processes which are inconsistent with best practices or DMH's LPS Designation Guidelines. If any inconsistencies or irregularities are identified such that individuals are not properly held and

conserved, DMH will re-train these facilities, create a corrective action plan, or take other necessary action.
Since conservatorship referrals are made by individual doctors affiliated with LPS designated facilities, DMH, as a long-term goal, will explore the possibility of the LPS designation of individual doctors in addition to the current designation of hospitals and facilities. This will enable DMH to hold not only the facility accountable for its referral decisions but also the treating doctors. As a result both may be subject to corrective action plans, the doctor may lose his or her ability to make LPS referrals, and the facility may lose its LPS designation.

**Recommendation 5**
**Support legislation which defines "grave disability" to include a person's inability to provide medical care for him or herself due to a mental disorder.**

Persons in need of involuntary care often have complex medical and substance use issues which are not sufficiently addressed with the existing definition of gravely disabled. This recommendation will address the issue by expanding the definition of gravely disabled to include a person's inability to care for his or her physical health. Assembly Member Phillip Chen introduced Assembly Bill No. 1539 (2017-2018 Reg. Sess.) to expand the definition of grave disability to include instances where an individual is unable to provide for his or her medical care due to his or her mental disorder. This legislation appears to have stalled and has little momentum in the Legislature. We propose that your Board make all efforts to revisit this legislation at the appropriate time or support others akin to this legislation.

**Recommendation 6**
**In order to increase access to the current inventory of acute psychiatric beds, facilitate the movement of individuals on LPS conservatorships from acute settings to other levels of care by increasing capacity and quality of care at licensed facilities [Board and Care, Enhanced Residential Service (ERS), Institute for Mentally Diseased (IMD)].**

This recommendation addresses the need to increase access to care and support for those in need of involuntary treatment. In addition to the 2,300 acute psychiatric beds in the County, there are 550 ERS beds and 1,054 IMD beds. ERS beds are a board-and-care-type facility with intensive treatment and additional support services. IMD beds are long-term locked facilities. The County would benefit from an expansion of ERS and IMD beds and the development of alternative care facilities to provide a more robust continuum of care.

This recommendation may be accomplished through supplemental funding for board and care providers and developing a Temporary Conservatorship Alternative Care facility. Supplemental payments to board and cares will improve living arrangements and services provided to clients while incentivizing facilities to take clients with complex needs.

DMH will consider developing a Temporary Conservatorship Alternative Care facility. This program would be limited to a certain population at hospitals that is non-violent and is not a flight risk, but has a history of non-compliance with discharges to open settings without conservatorship. It would provide an enriched environment for those who need a locked facility but, with extra support, could be conserved in a less restrictive, open setting. This innovative idea of placing a person on temporary conservatorship directly in the community from an acute setting is not without its challenges. To ensure compliance with the intent of the LPS Act while still placing the conservatee in the least restrictive environment, this program would require the addition of DMH psychiatrists who would be involved in acute and lower levels of care. These psychiatrists could provide testimony at conservatorship hearings, overcoming any evidentiary challenges that may arise with a referring doctor differing from the treating doctor at the lower level of care. The facilities and the treatment plans would need to provide sufficient evidence for supervision and involuntary medication, two hallmarks necessary to establish a LPS conservatorship.

**Recommendation 7**
**Develop new Full Service Partnership (FSP) models, including "FSP on steroids," "Street FSP," and Public Guardian FSP that are more flexible and provide intensive services, including housing and 24-hour access.**

This recommendation is intended to increase the intensity of FSP services to avoid the unnecessary hospitalization of individuals in crisis and increase services to conservatees. Several ideas and projects are in process or under consideration which will increase services to the homeless and increase the use of FSP programs countywide. For instance, DMH is releasing a Statement of Eligibility and Interest for new Homeless FSPs that will be funded by MHSA at a higher rate than the current FSPs and that could meet the interest of the "FSP on steroids." As part of increasing intensive services, Measure H is funding 16 new multidisciplinary outreach teams now which will expand to 25 in Fiscal Year (FY) 2017-2018 and then 36 in FY 2018-2019. These outreach teams, composed of team members with expertise in health, mental health, substance use, outreach and engagement, and peer support will be engaging the most vulnerable homeless persons throughout the County.

DMH is also expanding interim housing beds which will allow for quicker access to temporary housing while we work on a long-term housing plan. Assembly Bill No. 727 (2017-2018 Reg. Sess.) (AB 727), a County co-sponsored bill, may also assist with housing. If it passes, AB 727 will allow counties to spend MHSA funds on housing assistance for MHSA target populations regardless of whether the person participates in an FSP. This population includes persons who are mentally ill or who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention.

DMH is working on two additional proposals, Public Guardian FSP and DMH LPS Case Management Services, both of which would increase services to Public Guardian and conservatees.

The Public Guardian FSP will be a dedicated FSP program for Public Guardian clients. While Public Guardian clients have had some access to FSP programs, this FSP will be dedicated to Public Guardian conservatees who are high-utilizers of emergency rooms; frequently transition back and forth from locked to open settings; frequently abscond from facilities; are at risk of incarceration; and who have complex medical, substance use, and mental health issues. This program will be funded through MHSA.

DMH LPS Case Management Services, while still in development, will establish a dedicated team of clinicians and case managers from DMH to work with a dedicated unit of Public Guardian deputies and conservatees. The target population will be conservatees moving from locked facilities to community-based settings who require 24/7 support and services to maintain them in the least restrictive setting. These conservatees are anticipated to receive nearly daily visits from clinicians and a peer to ensure a smooth transition and ongoing stability in the community. This program will be funded through MHSA.

**Recommendation 8**
**Develop a pilot program using private entities to serve as LPS conservators.**

This recommendation will increase the capacity of the pool of conservators in the County but would not change the Public Guardian's responsibility of evaluating and recommending the most suitable conservator to the court. By building upon existing relationships, it would expand the County's ability to care and advocate for the seriously mentally ill. Specifically, DMH seeks to establish a pilot program with private advocacy groups to provide conservatorship services. Possible advocacy groups include the National Alliance on Mental Illness (NAMI), the Hollywood Business Improvement District, and related medical and case management service providers to the homeless. These advocacy groups may be able to serve as

suitable conservators because of their existing relationships with the proposed conservatees, which will further enhance and support their involvement. This type of relationship may allow these conservatees to be good candidates for the Temporary Conservatorship Alternative Care Facility project (Recommendation 6). DMH would commit support services to these conservators encouraging greater success. Support service ideas could include expansion of the Public Guardian-private conservator liaison program, access to clinicians, peer support, assistance with filing reappointment forms, benefit assistance. These conservators, if appointed by the court, would have to comply will all laws applicable to LPS conservators.

II. LPS Detentions and Conservatorship for Involuntary Treatment Due to Use of Controlled Substance

WIC § 5340 et seq. provides legal procedures for the custody, evaluation, and treatment of users of controlled substances, including narcotic drugs as defined in Health and Safety Code section 11019. If any person is a danger to others or to him or herself or is gravely disabled as a result of the use of controlled substances, then that person may be subject to an LPS hold or conservatorship.

**Recommendation 9**

**Establish a workgroup with support from the Health Agency and various stakeholders to explore the development of a program authorized under WIC § 5340 et seq.**

This recommendation serves as an opportunity to care for homeless individuals who are a danger to self, are a danger to others, or are gravely disabled due to substance use disorders, a population for which there could be greater access to mental health treatment through the LPS Act. Since these legal provisions have not been used in the County, DMH will evaluate potential challenges. A main challenge will be to qualitatively identify the subject population intended by this legislation and ensure that federal regulations have not made this program obsolete. Other challenges include determining the level of training and expertise required by those designated with section 5150 powers; determining and preparing for the potential impact on the Public Guardian, the Superior Court, County Counsel, the Public Defender, placements and treatment providers; as well as the ramifications related to SAPC (Substance Abuse Prevention and Control) and Public Health responsibilities and mandates.

III. Court-Ordered Evaluation Due to Mental Illness

WIC § 5200 et seq. provides that *any individual* who alleges that another person is, due to a mental disorder, a danger to self, a danger to others, or gravely disabled, may request a person or agency designated by the county (i.e., DMH) and

approved by the State Department of Health Care Services to file a petition with the superior court to order an evaluation of the subject person's condition. This legal procedure is rarely used but provides an alternate method to compel an evaluation to treat or, if applicable, conserve a person who requires treatment. The designated person or agency must file a petition if it determines there is probable cause to believe the initial allegations and the subject person refuses to voluntarily receive an evaluation or crisis intervention. If the court orders an evaluation and it determines that the subject person is a danger to self or to others or is gravely disabled, he or she may be detained and involuntarily treated for up to 72 hours. Thereafter, the person will be released, referred for care and treatment on a voluntary basis, detained further for intensive treatment, or recommended for LPS conservatorship.

**Recommendation 10**

**Explore, through the establishment of a workgroup, the use of the court-ordered evaluation process for treating those who are a danger to self, danger to others, or gravely disabled due to mental illness. The workgroup shall explore the practical implications of implementation of these court-ordered evaluations including the demand for services, required staffing, and impacts on the Mental Health Court.**

This recommendation utilizes an existing legal process that allows *anyone* to request a petition for evaluation of a mentally ill person's condition be filed with the superior court. This process may be commenced without the initiation of an involuntary 5150 hold by first responders or health care providers. It would allow friends and family members to request the County-designated agency to investigate and determine whether a court-ordered evaluation is warranted and, if so, to file the appropriate petition. This process would also allow the designated agency, as part of its assessment, to engage and offer crisis intervention services to these subject persons while they are in the community. As a legal process, a person's individual rights continue to be protected. False allegations that a person is a danger to self or others or gravely disabled may result in civil and criminal penalties. The person may remain within the community prior to the court-ordered evaluation and reasonable efforts must be made to safeguard the person's personal property while he or she is undergoing the evaluation.

IV. Assisted Outpatient Treatment (Laura's Law)

WIC § 5345 et seq., also known as Laura's Law, provides for assisted outpatient treatment (AOT). It allows counties to pursue court-ordered outpatient treatment for people with serious mental illness while ensuring individual's due process rights are recognized. AOT has been shown to be effective in reducing re-

hospitalizations, incarcerations, victimizations, episodes of violence, and homelessness.

On July 15, 2014, your Board voted to implement Laura's Law countywide as a tool for making treatment possible for persons with severe mental illness who are too ill to seek help for themselves. Laura's Law authorizes the Director of DMH, after exploring all other voluntary methods of treatment, to petition for court-ordered outpatient treatment. Such treatment may be ordered if the court finds, by clear and convincing evidence, that the subject person satisfies all of the statutory AOT eligibility criteria. This criteria includes, but is not limited to, the person: having a serious mental illness, being unlikely to survive safely in the community, having a history of treatment non-compliance, continuing to refuse offered mental health services, and being at substantial risk for deterioration or detention on an LPS hold.
Through the AOT process, the subject person is afforded all due process protections. If, however, that person fails to comply with court-ordered AOT, rejects efforts made to solicit compliance, and needs to be involuntarily detained for evaluation, the subject person may be placed on a 5150 hold for up to 72 hours. He or she may be further detained for evaluation and treatment only if the subject person meets the applicable criteria under the LPS Act.

**Recommendation 11**
**Further expand the use of AOT to maximize both voluntary treatment and increase court-ordered treatment as applicable.**

**Recommendation 12**
**Explore court-ordered administration of antipsychotic medication for AOT candidates.**

These recommendations support the increased filing of AOT petitions as well as seeking court orders to involuntarily administer medication in order to provide necessary stabilizing treatment for persons affected by mental illness.

Implementation of Laura's Law countywide started in May 2015 and allows DMH to serve seriously mentally ill persons at substantial risk of deterioration or detention under an LPS hold as a direct result of poor psychiatric treatment compliance. AOT has been enhanced since 2015 with the inclusion of services from FSPs.

In an effort to further maximize AOT, DMH will evaluate its referral review process by qualitatively examining the AOT eligibility criteria; expand its use to all aspects of the continuum of care, explore solutions to challenges raised by private health insurance; and analyze other relevant issues impacting the program.

Additionally, where appropriate, DMH will seek court-ordered medication for those individuals who are candidates for AOT to stabilize those individuals, to encourage successful AOT, and potentially to reduce the need for future detention or conservatorship. Laura's Law does not expressly authorize or prohibit the use of involuntary medication. Rather, it provides that a separate order must be obtained prior to the involuntary administration of antipsychotic medication in accordance with existing law. Thus, a medication capacity (*Riese*) hearing petition should be filed concurrently with an AOT petition to obtain a judicial determination that an individual lacks the capacity to rationally decide whether to refuse or consent to medication.

These recommendations will require additional County Counsel and DMH staff including DMH psychiatrists.

V. Court-Ordered Medical Treatment

Probate Code section 3200 et seq. allows a third-party to petition the superior court to make health care decisions and provide informed consent related to a specific medical procedure on behalf of a patient that lacks capacity to make his or her own health care decisions. After determining a patient lacks capacity based on a doctor's declaration, a court may grant decision-making authority to a third party, who can then authorize medical treatment on the patient's behalf. The County uses this process in its hospitals for patients who are incapacitated in order to perform non-emergency but life-saving procedures. In addition to the County's efforts, these petitions may also be filed by a friend, relative, or other interested person on the patient's behalf. The authority granted by these petitions is limited to a particular treatment or procedure identified by the patient's treating physician and authority to continue making long-term medical decisions should be pursued by a petition for conservatorship.

**Recommendation 13**

**Create a workgroup with support from the Health Agency and stakeholders to explore the feasibility of using "treating street doctors" associated with advocacy groups to file Probate Code section 3200 petitions to provide involuntary medical treatment to those found to lack the capacity to make their own healthcare decisions.**

This recommendation may serve as a temporary solution pending any legislative change to the definition of "gravely disabled." It will allow street doctors with existing relationships with homeless individuals to seek necessary medical attention for those who lack the capacity to seek treatment for themselves. Since the person would typically not be an existing patient in a hospital, the process to file and obtain an order from the court may take longer than one week. This may

cause a work impact for the superior court and the Public Guardian with a possible increase in the number of petitions filed as well as referrals to the Public Guardian for probate conservatorships. Increased probate conservatorships will further exacerbate the lack of sufficient care facilities available for this population and will require the development and funding of new placement resources.

JES:tld

c: Executive Office, Board of Supervisors
Chief Executive Office

**Kathy Jones**

**From:** Kerry Morrison <Kerry@hollywoodbid.org>
**Sent:** Monday, October 16, 2017 11:20 AM
**To:** Caroline Kelly;barbarabwilsonlcsw@gmail.com;brittney@namilaccc.org;Canetana Hurd
**Subject:** Re: Conference call - 888 204 5987 #9639884

Caroline, we are on a different number. Call here

641-715-3620

960217
Sent using OWA for iPad

---

**From:** Caroline Kelly <chairlamhc@gmail.com>
**Sent:** Monday, October 16, 2017 11:18:47 AM
**To:** Kerry Morrison; barbarabwilsonlcsw@gmail.com; brittney@namilaccc.org; Cy Cantena Hurd
**Subject:** Fwd: Conference call - 888 204 5987 #9639884

Are we all calling this number?

Sent from my iPhone

Begin forwarded message:

> **From:** Barbara B Wilson <batnp@hotmail.com>
> **Date:** October 13, 2017 at 8:23:43 PM PDT
> **To:** "brittneyweissman@gmail.com" <brittneyweissman@gmail.com>, Mary Marx <MMarx@dmh.lacounty.gov>, Gilda Ramos <GRamos@dmh.lacounty.gov>, "kerry@hollywoodbid.org" <kerry@hollywoodbid.org>, Brittney Weissman <brittney@namilaccc.org>, Commissioner Kelly <ChairLAMHC@gmail.com>
> **Subject: Conference call - 888 204 5987 #9639884**

**Kathy Jones**

| | |
|---|---|
| **From:** | Caroline Kelly <chairlamhc@gmail.com> |
| **Sent:** | Monday, October 16, 2017 11:19 AM |
| **To:** | Kerry@hollywoodbid.org;barbarabwilsonlcsw@gmail.com;brittney@namilaccc.org;Canetana Hurd |
| **Subject:** | Fwd: Conference call - 888 204 5987 #9639884 |
| **Attachments:** | mime-attachment.ics |

Are we all calling this number?

Sent from my iPhone

Begin forwarded message:

> **From:** Barbara B Wilson <batnp@hotmail.com>
> **Date:** October 13, 2017 at 8:23:43 PM PDT
> **To:** "brittneyweissman@gmail.com" <brittneyweissman@gmail.com>, Mary Marx <MMarx@dmh.lacounty.gov>, Gilda Ramos <GRamos@dmh.lacounty.gov>, "kerry@hollywoodbid.org" <kerry@hollywoodbid.org>, Brittney Weissman <brittney@namilaccc.org>, Commissioner Kelly <ChairLAMHC@gmail.com>
> **Subject: Conference call - 888 204 5987 #9639884**

**Kathy Jones**

| | |
|---|---|
| **From:** | Brittney Weissman <brittney@namilaccc.org> |
| **Sent:** | Monday, October 16, 2017 11:38 AM |
| **To:** | Kerry Morrison;Mary Marx |
| **Cc:** | Caroline Kelly;barbarabwilsonlcsw@gmail.com;Canetana Hurd |
| **Subject:** | Re: Conference call - 888 204 5987 #9639884 |
| **Attachments:** | Standard of Care for the Mentally Ill 040417.pdf; Report Back Standard of Care for Mentally Ill 091817.pdf |

Here're the reports to which I'm referring regarding tomorrow's BOS meeting.

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
3250 Wilshire Boulevard, Suite 1501
Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
http://secure-web.cisco.com/1321Kq6xl9Oj2Pe6gBRiwN6QNIZHK3UpXx3GR4Rqy479wdg4Yu0Ac-uhW7DuYUPUJViDyhkFYIYp2pw6DR6mzcQTHoYBcdWWd4vUsJbh4caBHL1Z-iO3K3tkpr6LOIM4qWBVAXjK8HuiuIB8JhAEp_EdPgE8-hshF4UwqsKUpJbSYWEMRP-m9Ux5vK0HtcAZ6ojmXerFcUC5qAmwuQdV5Rjc8zyYxuc1hKU6KO_MzwROO-_7jHMsdf9ejSE1PQdxVhHU_gITGPVpzOFgKDl1sFHeA4N65OSCWEO9T9aX48OepTFHqiD565FVOMtqJauBnG8UNdh-dfM_IGeW-UK2PYzF6gWKziWGi9rJDrCAGqZbcqjMpcLq9XVrfOcDhZGITm6oPWMKAxeujfFGtekOj2A/http%3A%2F%2Fwww.namilacc.org
www.facebook.com/NAMILACC.org

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> **Subject: Conference call - 888 204 5987 #9639884**

AGN. NO._____

MOTION BY SUPERVISOR KATHRYN BARGER April 4, 2017

**Standard of Care for the Mentally Ill**

On March 7, 2017, Los Angeles County residents passed Measure H; a quarter cent sales tax over a ten year period to provide essential resources to address the County's homeless crisis. The passage of this measure is a tremendous step forward in the County's fight against homelessness.

The most challenging obstacle that the County faces over the next ten years is the issue of chronic homelessness. Chronic homelessness is the face of the County's homelessness crisis. The term "chronic" attaches a distinct definition to homelessness, involving either long-term and/or repeated bouts of homelessness coupled with a physical and/or mental disability. Those that are chronically homeless are our most vulnerable population in need of treatment and care.

Within the County's chronically homeless population there is a significant segment of individuals that refuse any kind of treatment and/or care. Although they refuse care, it is apparent that they are in desperate need of treatment and unable to make a conscious decision to seek or accept proper treatment and provide for basic personal needs (such as food, clothing, and shelter). This presents a significant truth; he or she is a danger to themselves.

Section 5150 of the California Welfare and Institutions Code authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes him or her a danger to him-or herself, a danger to others, and/or is *gravely disabled.* The hold duration is allotted for up to a 72 hour period, a time span in which it

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Hahn _____

Barger _____

Ridley-Thomas _____

is impossible to provide meaningful treatment to someone that is facing severe mental disability. After a 72 hour hold the individual is back on the streets and concludes that treatment is ineffective thus, increasing their resistance to treatment in the future. This treatment option is, in many cases, vastly insufficient.

The lack of mental healthcare beyond a temporary emergency hold has been realized in other states as well. For example, in early 2014, Virginia State Senator Creigh Deeds (D-Bath) introduced legislation to address the lack of treatment beyond an emergency temporary hold. Virginia Senate Bill 260 directed the Department of Behavioral Health and Developmental Services to establish an acute psychiatric bed registry that provides real-time information on the availability of beds in public and private psychiatric facilities and residential crisis stabilization units for individuals who meet the criteria for temporary hold and are in need of extended care. This legislation was authored by Senator Deeds after his son committed suicide following his release from a temporary emergency hold order. Virginia's SB 260 ultimately passed and was signed into law by the Governor.

There needs to be a higher standard of mental healthcare. With a short ten year window to address homelessness using Measure H funds, the County must review and revisit the application of California Lanterman-Petris-Short Act to ensure that we have requisite authority to provide care for those who are suffering from mental illness and are unwilling and/or incapable of accepting care.

**I, THEREFORE, MOVE** that the Board of Supervisors direct County Counsel to work with the Department of Mental Health to provide a legal analysis, interpretation, and application of all existing State Mental Health Laws, along with recommendations on ways the County can achieve requisite authority to provide humane treatment for those who are suffering from mental illness and are unwilling and/or incapable of accepting care. The analysis should include recommendations for amendments to existing laws, if necessary, and report back in 45 days.

# # #

KB:EM

**LOS ANGELES COUNTY**
**DEPARTMENT OF MENTAL HEALTH**

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

September 18, 2017

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

Mary C. Wickham
County Counsel

SUBJECT: **STANDARD OF CARE FOR MENTALLY ILL (ITEM NO. 5, AGENDA OF APRIL 4, 2017)**

On April 4, 2017, your Board instructed the Department of Mental Health (DMH) in collaboration with County Counsel and other relevant departments to analyze existing State mental health laws and provide recommendations for the humane treatment of people living with mental illness and who are unwilling or incapable of accepting care. Additionally, you asked us to address potential risks to civil liberties if our recommendations triggered them and to assess the potential expansion of necessary mental health resources and housing based on current and future funding streams.

Our departments established a working group to address these issues and to develop recommendations. As part of this process, DMH convened a symposium with a full range of County and community stakeholders to specifically address approaches to engaging and delivering mental health services to chronically homeless populations suffering from serious mental illness. This symposium served as a springboard to review and revisit the application of the Lanterman-Petris-Short (LPS) Act and other related laws to empower the County to better care for this vulnerable population.

As part of an ongoing collaborative effort, the work group's recommendations were shared, developed, and discussed with these stakeholders. This final set of recommendations is a direct product of this collaboration which furthers the collective goal of humanely caring for homeless persons with mental illness.

This report back sets forth a list of recommendations to humanely treat those suffering from mental illness. Most recommendations are supported by existing law; only one requires legislative change. Each recommendation focuses on the engagement, care, and sustainability of care for those in need of involuntary mental health treatment services without infringing upon the civil liberties of those individuals.

**BACKGROUND**

State and federal law recognizes that every adult with the capacity to make health care decisions has the fundamental right of self-determination over his or her body. While every competent individual has the Constitutional right to refuse any medical treatment, courts have consistently held that this right is not absolute and must yield to compelling State interests. Such interests include the protection of public health and safety from those who present a danger to themselves or others, as well as the protection of persons who cannot care for themselves.

In California, the principal law governing mental health evaluation and treatment is the LPS Act (Welfare and Institutions Code (WIC), § 5000 et seq.). The law sets forth the procedures that law enforcement and health care providers must follow to detain a person for involuntary mental health evaluation and treatment as well as assignment of a surrogate decision-maker. Its purpose is to provide prompt, incremental treatment to persons with mental disorders, to protect public safety, and to safeguard the rights of such persons through judicial review.

We discuss our recommendations and rationales in the context of the key areas of the LPS Act, including the need for resources and housing, through identified funding streams, where applicable. These recommendations address issues relating to detention and conservatorship criteria, transportation, as well as increased access to care.

**DISCUSSION/RECOMMENDATIONS**

I. <u>LPS Detentions and Conservatorship for Involuntary Treatment Due to Mental Illness</u>

Under the LPS Act, persons who pose a danger to self, pose a danger to others, or are gravely disabled may be detained for varying periods of time in designated mental health facilities for involuntary evaluation and treatment. A person is gravely disabled when he or she is unable to provide food, clothing, or shelter for him or herself due to his or her mental disorder and cannot or will not agree to voluntary treatment. The detention period, also referred to as a *hold*, usually depends on the nature and duration of the person's illness and is subject to judicial review. Typically, such persons are initially detained by first responders or health care

professionals for up to 72 hours, pursuant to WIC § 5150. This 72-hour period is commonly referred to as a *5150 hold*. Persons may be detained for an additional 14-day period for intensive treatment. For persons who present an imminent threat of suicide during the 14-day period or 72-hour evaluation period, a second 14-day period for such treatment may be authorized.

If at the end of the first 14-day hold, the person continues to be in need of care due to a grave disability, an additional 30-day period of intensive treatment may be authorized or a petition for temporary conservatorship may be filed with the court. If a temporary conservatorship is granted, it lasts a maximum of 30 days and must run concurrently with the 30-day period for intensive treatment because a gravely disabled person may not be held involuntarily for more than a total of 47 days from the initial 72-hour hold.

LPS conservatorship is a process in which the court appoints a conservator to manage a conservatee's mental health treatment, including placement and medication. At any time during an LPS hold for evaluation and treatment, if a person is considered to be gravely disabled, a treating physician may recommend the public guardian petition the court to establish a conservatorship over the person. The proposed conservatee has the right to a jury trial, and the jury's determination of gravely disabled must be unanimous and beyond a reasonable doubt. If granted, the conservatorship lasts for a period of one year, and the conservator may petition the court for reappointment each year. During the conservatorship period, the conservatee has the right to request the court rehear the conservatorship decision once every six months.

Although the public guardian must recommend the most suitable person, corporation, or other public or private agency, the court has the sole discretion in appointing the conservator. In making the selection, the court is guided by the best interests of the proposed conservatee, the public guardian's recommendation, and the statutory order of preference when there is more than one conservator recommended. If there is no suitable person or entity willing or able to serve as conservator, the court will appoint the public guardian as conservator. Once appointed, the conservator will have the legal power to make decisions regarding placement and to require the conservatee to receive mental health treatment and psychotropic medications as indicated.

Our analysis of the LPS Act and interaction with stakeholders affirms that a lack of treatment for persons with serious mental illness may result in chronic homelessness and instability for those persons. These recommendations address ways to interrupt the cycle of homelessness through the engagement and care of

those in need of mental health treatment to ensure consistent, lasting care in the least restrictive and most stable placements.

**Recommendation 1**
**Ensure accurate and consistent interpretation of the proper basis for finding probable cause for grave disability, danger to self, and danger to others for purposes of detention and establish a robust, consistent training for first responders and clinicians based.**

This recommendation addresses the lack of consistency among first responders, clinicians, and others in determining when to detain persons under the LPS Act. The development of an accurate and consistent interpretation of causes for involuntary detention under the LPS Act will improve access to care. County Counsel, DMH, and Public Guardian can take the lead in this effort. Developing this interpretation can be combined with robust training of first responders and clinicians to consistently assess for the presence of probable cause for detention by finding danger to self, danger to others, or grave disability. Persons deteriorating as a result of their inability to care for their physical health could be considered a danger to self as well as gravely disabled. A key aspect of such training should be more comprehensive assessment of danger or disability resulting from potential or actual deterioration of an individual's condition due to medical or behavioral issues over time, especially under the initial involuntary holds. The training will include consideration of non-imminent harm factors as well as data collection reflecting the historical course of a person's mental disorder. A checklist with concrete elements may be utilized to further ensure consistency.

Such training can be developed through DMH with the Office of the Medical Director, the Public Guardian, and the Office of Patients' Rights. Resources for such efforts may come from a variety of sources, including Mental Health Services Act (MHSA) funding.

**Recommendation 2**
**Transition current Psychiatric Mobile Response Team (PMRT) operations, practice, and policy to grow DMH's real time mobile response capacity in the context of acute and urgent scenarios by: 1) increasing the number of active vehicles as well as personnel (clinician and peer teams) deployed to each Service Area, and 2) expanding the range of activities delivered by each mobile team to include not only outreach and hospitalization under 5150 detention but also real time engagement and triage (with transportation as indicated) for clients needing shelter, respite and/or treatment otherwise.**

This recommendation addresses a need for proactive engagement and triage that is better tailored, more humane, timely, cost effective, and efficient with an increased reliance on services and non-inpatient care settings such as Urgent Care Centers (UCC), Crisis Residential Treatment Programs, and other treatment and residential resources.

The need for ambulance and law enforcement assistance, critical in certain scenarios, will be determined in the field by PMRT teams who can leverage these specialized services more selectively as indicated by clinical demand. DMH will utilize MHSA funding for additional clinicians and vehicles needed to implement this recommendation.

**Recommendation 3**
**Develop guidelines and outreach programs for law enforcement assistance when DMH crisis teams (PMRT) determine the presence of probable cause for a 5150 hold of individuals who resist assessment or transport to an LPS designated facility.**

This recommendation addresses the need to engage and assist persons who are resistant or assaultive but in need of hospitalization. Law enforcement may hesitate to physically restrain such persons due to concerns about preserving the individual's civil rights and the reasonable basis for restraint. Absent assistance by personnel trained and equipped to detain and transport individuals who are likely to physically resist or who are potentially assaultive, DMH teams are forced to leave such people in the field even though they meet criteria for detention under section 5150. This restricts access to care and heightens the risk of harm to both the community and those not detained. Under collaboratively developed guidelines, DMH and County Counsel will work with law enforcement to coordinate efforts responding to such situations.

**Recommendation 4**
**Develop consistency among LPS designated facilities and their medical staffs in submitting referrals for conservatorship.**

This recommendation addresses the lack of consistency among various LPS designated facilities in determining when to refer a person to the Public Guardian for LPS conservatorship. Such consistency is expected to ensure greater access to care by promoting the congruous application of LPS referral practices among LPS designated facilities. DMH will review the practices of these facilities to identify any differences in their conservatorship referral processes which are inconsistent with best practices or DMH's LPS Designation Guidelines. If any inconsistencies or irregularities are identified such that individuals are not properly held and

conserved, DMH will re-train these facilities, create a corrective action plan, or take other necessary action.
Since conservatorship referrals are made by individual doctors affiliated with LPS designated facilities, DMH, as a long-term goal, will explore the possibility of the LPS designation of individual doctors in addition to the current designation of hospitals and facilities. This will enable DMH to hold not only the facility accountable for its referral decisions but also the treating doctors. As a result both may be subject to corrective action plans, the doctor may lose his or her ability to make LPS referrals, and the facility may lose its LPS designation.

**Recommendation 5**
**Support legislation which defines "grave disability" to include a person's inability to provide medical care for him or herself due to a mental disorder.**

Persons in need of involuntary care often have complex medical and substance use issues which are not sufficiently addressed with the existing definition of gravely disabled. This recommendation will address the issue by expanding the definition of gravely disabled to include a person's inability to care for his or her physical health. Assembly Member Phillip Chen introduced Assembly Bill No. 1539 (2017-2018 Reg. Sess.) to expand the definition of grave disability to include instances where an individual is unable to provide for his or her medical care due to his or her mental disorder. This legislation appears to have stalled and has little momentum in the Legislature. We propose that your Board make all efforts to revisit this legislation at the appropriate time or support others akin to this legislation.

**Recommendation 6**
**In order to increase access to the current inventory of acute psychiatric beds, facilitate the movement of individuals on LPS conservatorships from acute settings to other levels of care by increasing capacity and quality of care at licensed facilities [Board and Care, Enhanced Residential Service (ERS), Institute for Mentally Diseased (IMD)].**

This recommendation addresses the need to increase access to care and support for those in need of involuntary treatment. In addition to the 2,300 acute psychiatric beds in the County, there are 550 ERS beds and 1,054 IMD beds. ERS beds are a board-and-care-type facility with intensive treatment and additional support services. IMD beds are long-term locked facilities. The County would benefit from an expansion of ERS and IMD beds and the development of alternative care facilities to provide a more robust continuum of care.

This recommendation may be accomplished through supplemental funding for board and care providers and developing a Temporary Conservatorship Alternative Care facility. Supplemental payments to board and cares will improve living arrangements and services provided to clients while incentivizing facilities to take clients with complex needs.

DMH will consider developing a Temporary Conservatorship Alternative Care facility. This program would be limited to a certain population at hospitals that is non-violent and is not a flight risk, but has a history of non-compliance with discharges to open settings without conservatorship. It would provide an enriched environment for those who need a locked facility but, with extra support, could be conserved in a less restrictive, open setting. This innovative idea of placing a person on temporary conservatorship directly in the community from an acute setting is not without its challenges. To ensure compliance with the intent of the LPS Act while still placing the conservatee in the least restrictive environment, this program would require the addition of DMH psychiatrists who would be involved in acute and lower levels of care. These psychiatrists could provide testimony at conservatorship hearings, overcoming any evidentiary challenges that may arise with a referring doctor differing from the treating doctor at the lower level of care. The facilities and the treatment plans would need to provide sufficient evidence for supervision and involuntary medication, two hallmarks necessary to establish a LPS conservatorship.

**Recommendation 7**
**Develop new Full Service Partnership (FSP) models, including "FSP on steroids," "Street FSP," and Public Guardian FSP that are more flexible and provide intensive services, including housing and 24-hour access.**

This recommendation is intended to increase the intensity of FSP services to avoid the unnecessary hospitalization of individuals in crisis and increase services to conservatees. Several ideas and projects are in process or under consideration which will increase services to the homeless and increase the use of FSP programs countywide. For instance, DMH is releasing a Statement of Eligibility and Interest for new Homeless FSPs that will be funded by MHSA at a higher rate than the current FSPs and that could meet the interest of the "FSP on steroids." As part of increasing intensive services, Measure H is funding 16 new multidisciplinary outreach teams now which will expand to 25 in Fiscal Year (FY) 2017-2018 and then 36 in FY 2018-2019. These outreach teams, composed of team members with expertise in health, mental health, substance use, outreach and engagement, and peer support will be engaging the most vulnerable homeless persons throughout the County.

DMH is also expanding interim housing beds which will allow for quicker access to temporary housing while we work on a long-term housing plan. Assembly Bill No. 727 (2017-2018 Reg. Sess.) (AB 727), a County co-sponsored bill, may also assist with housing. If it passes, AB 727 will allow counties to spend MHSA funds on housing assistance for MHSA target populations regardless of whether the person participates in an FSP. This population includes persons who are mentally ill or who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention.

DMH is working on two additional proposals, Public Guardian FSP and DMH LPS Case Management Services, both of which would increase services to Public Guardian and conservatees.

The Public Guardian FSP will be a dedicated FSP program for Public Guardian clients. While Public Guardian clients have had some access to FSP programs, this FSP will be dedicated to Public Guardian conservatees who are high-utilizers of emergency rooms; frequently transition back and forth from locked to open settings; frequently abscond from facilities; are at risk of incarceration; and who have complex medical, substance use, and mental health issues. This program will be funded through MHSA.

DMH LPS Case Management Services, while still in development, will establish a dedicated team of clinicians and case managers from DMH to work with a dedicated unit of Public Guardian deputies and conservatees. The target population will be conservatees moving from locked facilities to community-based settings who require 24/7 support and services to maintain them in the least restrictive setting. These conservatees are anticipated to receive nearly daily visits from clinicians and a peer to ensure a smooth transition and ongoing stability in the community. This program will be funded through MHSA.

**Recommendation 8**
**Develop a pilot program using private entities to serve as LPS conservators.**

This recommendation will increase the capacity of the pool of conservators in the County but would not change the Public Guardian's responsibility of evaluating and recommending the most suitable conservator to the court. By building upon existing relationships, it would expand the County's ability to care and advocate for the seriously mentally ill. Specifically, DMH seeks to establish a pilot program with private advocacy groups to provide conservatorship services. Possible advocacy groups include the National Alliance on Mental Illness (NAMI), the Hollywood Business Improvement District, and related medical and case management service providers to the homeless. These advocacy groups may be able to serve as

suitable conservators because of their existing relationships with the proposed conservatees, which will further enhance and support their involvement. This type of relationship may allow these conservatees to be good candidates for the Temporary Conservatorship Alternative Care Facility project (Recommendation 6). DMH would commit support services to these conservators encouraging greater success. Support service ideas could include expansion of the Public Guardian-private conservator liaison program, access to clinicians, peer support, assistance with filing reappointment forms, benefit assistance. These conservators, if appointed by the court, would have to comply will all laws applicable to LPS conservators.

II. LPS Detentions and Conservatorship for Involuntary Treatment Due to Use of Controlled Substance

WIC § 5340 et seq. provides legal procedures for the custody, evaluation, and treatment of users of controlled substances, including narcotic drugs as defined in Health and Safety Code section 11019. If any person is a danger to others or to him or herself or is gravely disabled as a result of the use of controlled substances, then that person may be subject to an LPS hold or conservatorship.

**Recommendation 9**

**Establish a workgroup with support from the Health Agency and various stakeholders to explore the development of a program authorized under WIC § 5340 et seq.**

This recommendation serves as an opportunity to care for homeless individuals who are a danger to self, are a danger to others, or are gravely disabled due to substance use disorders, a population for which there could be greater access to mental health treatment through the LPS Act. Since these legal provisions have not been used in the County, DMH will evaluate potential challenges. A main challenge will be to qualitatively identify the subject population intended by this legislation and ensure that federal regulations have not made this program obsolete. Other challenges include determining the level of training and expertise required by those designated with section 5150 powers; determining and preparing for the potential impact on the Public Guardian, the Superior Court, County Counsel, the Public Defender, placements and treatment providers; as well as the ramifications related to SAPC (Substance Abuse Prevention and Control) and Public Health responsibilities and mandates.

III. Court-Ordered Evaluation Due to Mental Illness

WIC § 5200 et seq. provides that *any individual* who alleges that another person is, due to a mental disorder, a danger to self, a danger to others, or gravely disabled, may request a person or agency designated by the county (i.e., DMH) and

approved by the State Department of Health Care Services to file a petition with the superior court to order an evaluation of the subject person's condition. This legal procedure is rarely used but provides an alternate method to compel an evaluation to treat or, if applicable, conserve a person who requires treatment. The designated person or agency must file a petition if it determines there is probable cause to believe the initial allegations and the subject person refuses to voluntarily receive an evaluation or crisis intervention. If the court orders an evaluation and it determines that the subject person is a danger to self or to others or is gravely disabled, he or she may be detained and involuntarily treated for up to 72 hours. Thereafter, the person will be released, referred for care and treatment on a voluntary basis, detained further for intensive treatment, or recommended for LPS conservatorship.

Recommendation 10

**Explore, through the establishment of a workgroup, the use of the court-ordered evaluation process for treating those who are a danger to self, danger to others, or gravely disabled due to mental illness. The workgroup shall explore the practical implications of implementation of these court-ordered evaluations including the demand for services, required staffing, and impacts on the Mental Health Court.**

This recommendation utilizes an existing legal process that allows *anyone* to request a petition for evaluation of a mentally ill person's condition be filed with the superior court. This process may be commenced without the initiation of an involuntary 5150 hold by first responders or health care providers. It would allow friends and family members to request the County-designated agency to investigate and determine whether a court-ordered evaluation is warranted and, if so, to file the appropriate petition. This process would also allow the designated agency, as part of its assessment, to engage and offer crisis intervention services to these subject persons while they are in the community. As a legal process, a person's individual rights continue to be protected. False allegations that a person is a danger to self or others or gravely disabled may result in civil and criminal penalties. The person may remain within the community prior to the court-ordered evaluation and reasonable efforts must be made to safeguard the person's personal property while he or she is undergoing the evaluation.

IV. Assisted Outpatient Treatment (Laura's Law)

WIC § 5345 et seq., also known as Laura's Law, provides for assisted outpatient treatment (AOT). It allows counties to pursue court-ordered outpatient treatment for people with serious mental illness while ensuring individual's due process rights are recognized. AOT has been shown to be effective in reducing re-

hospitalizations, incarcerations, victimizations, episodes of violence, and homelessness.

On July 15, 2014, your Board voted to implement Laura's Law countywide as a tool for making treatment possible for persons with severe mental illness who are too ill to seek help for themselves. Laura's Law authorizes the Director of DMH, after exploring all other voluntary methods of treatment, to petition for court-ordered outpatient treatment. Such treatment may be ordered if the court finds, by clear and convincing evidence, that the subject person satisfies all of the statutory AOT eligibility criteria. This criteria includes, but is not limited to, the person: having a serious mental illness, being unlikely to survive safely in the community, having a history of treatment non-compliance, continuing to refuse offered mental health services, and being at substantial risk for deterioration or detention on an LPS hold.
Through the AOT process, the subject person is afforded all due process protections. If, however, that person fails to comply with court-ordered AOT, rejects efforts made to solicit compliance, and needs to be involuntarily detained for evaluation, the subject person may be placed on a 5150 hold for up to 72 hours. He or she may be further detained for evaluation and treatment only if the subject person meets the applicable criteria under the LPS Act.

**Recommendation 11**
**Further expand the use of AOT to maximize both voluntary treatment and increase court-ordered treatment as applicable.**

**Recommendation 12**
**Explore court-ordered administration of antipsychotic medication for AOT candidates.**

These recommendations support the increased filing of AOT petitions as well as seeking court orders to involuntarily administer medication in order to provide necessary stabilizing treatment for persons affected by mental illness.

Implementation of Laura's Law countywide started in May 2015 and allows DMH to serve seriously mentally ill persons at substantial risk of deterioration or detention under an LPS hold as a direct result of poor psychiatric treatment compliance. AOT has been enhanced since 2015 with the inclusion of services from FSPs.

In an effort to further maximize AOT, DMH will evaluate its referral review process by qualitatively examining the AOT eligibility criteria; expand its use to all aspects of the continuum of care, explore solutions to challenges raised by private health insurance; and analyze other relevant issues impacting the program.

Additionally, where appropriate, DMH will seek court-ordered medication for those individuals who are candidates for AOT to stabilize those individuals, to encourage successful AOT, and potentially to reduce the need for future detention or conservatorship. Laura's Law does not expressly authorize or prohibit the use of involuntary medication. Rather, it provides that a separate order must be obtained prior to the involuntary administration of antipsychotic medication in accordance with existing law. Thus, a medication capacity (*Riese*) hearing petition should be filed concurrently with an AOT petition to obtain a judicial determination that an individual lacks the capacity to rationally decide whether to refuse or consent to medication.

These recommendations will require additional County Counsel and DMH staff including DMH psychiatrists.

V. Court-Ordered Medical Treatment

Probate Code section 3200 et seq. allows a third-party to petition the superior court to make health care decisions and provide informed consent related to a specific medical procedure on behalf of a patient that lacks capacity to make his or her own health care decisions. After determining a patient lacks capacity based on a doctor's declaration, a court may grant decision-making authority to a third party, who can then authorize medical treatment on the patient's behalf. The County uses this process in its hospitals for patients who are incapacitated in order to perform non-emergency but life-saving procedures. In addition to the County's efforts, these petitions may also be filed by a friend, relative, or other interested person on the patient's behalf. The authority granted by these petitions is limited to a particular treatment or procedure identified by the patient's treating physician and authority to continue making long-term medical decisions should be pursued by a petition for conservatorship.

**Recommendation 13**

**Create a workgroup with support from the Health Agency and stakeholders to explore the feasibility of using "treating street doctors" associated with advocacy groups to file Probate Code section 3200 petitions to provide involuntary medical treatment to those found to lack the capacity to make their own healthcare decisions.**

This recommendation may serve as a temporary solution pending any legislative change to the definition of "gravely disabled." It will allow street doctors with existing relationships with homeless individuals to seek necessary medical attention for those who lack the capacity to seek treatment for themselves. Since the person would typically not be an existing patient in a hospital, the process to file and obtain an order from the court may take longer than one week. This may

cause a work impact for the superior court and the Public Guardian with a possible increase in the number of petitions filed as well as referrals to the Public Guardian for probate conservatorships. Increased probate conservatorships will further exacerbate the lack of sufficient care facilities available for this population and will require the development and funding of new placement resources.

JES:tld

c: Executive Office, Board of Supervisors
Chief Executive Office

**Kathy Jones**

**From:** Rev. Kathy Cooper Ledesma <revkathy@hollywoodumc.org>
**Sent:** Thursday, October 05, 2017 5:24 PM
**To:** Canetana Hurd
**Cc:** Angelica Ayala;Elan Shultz;Sarkis Semerdjyan
**Subject:** Re: Interest in serving on the LAC Mental Health Commission

Thank you!

On Thu, Oct 5, 2017 at 5:20 PM Canetana Hurd <CHurd@dmh.lacounty.gov> wrote:

Hello Rev. Cooper,

I am forwarding your interest email to the Board of Supervisors' Health Deputies in Districts 1 and 3 who are cc'd. There is a vacancy on the commission in District 3. The Mental Health Commission makes recommendations but the board of supervisors appoint commissioners to serve on the commission.

**From:** Rev. Kathy Cooper Ledesma [mailto:revkathy@hollywoodumc.org]
**Sent:** Thursday, October 05, 2017 4:24 PM
**To:** Canetana Hurd
**Subject:** Re: Interest in serving on the LAC Mental Health Commission

Hi there -- have decisions been made?

with thanks,

Kathy

On Wed, Jul 19, 2017 at 11:07 AM, Canetana Hurd <CHurd@dmh.lacounty.gov> wrote:

Hello Rev. Cooper,

I am acknowledging your interest in serving on the LAC Mental Health Commission. Thank you

**From:** Rev. Kathy Cooper Ledesma [mailto:revkathy@hollywoodumc.org]
**Sent:** Tuesday, July 18, 2017 3:10 PM
**To:** Canetana Hurd
**Subject:** Interest in serving on the LAC Mental Health Commission

Hi Canetana --

I am interested in serving on the LAC Mental Health Commission, and write at your request through Kerry Morrison.

I serve as the Senior Pastor of Hollywood United Methodist Church, in Supervisorial District 3. My residence is in the Eagle Rock area of Los Angeles, in the 1st Supervisorial District.

My interest in serving on the commission comes as a result of my longstanding work with the least and the lost in our community. From running an emergency food and shelter program in the 1980s to our congregation's current homeless outreach work in the heart of Hollywood, I am committed to the physical and mental well-being of all.

One of my specific areas of interest would be assisting the Commission in leading the County and the State in defining a uniform interpretation of "gravely disabled." Last April our church hosted a convening, led by Kerry Morrison, of service providers, doctors and government leaders on this very issue. For the past 16 years our congregation has cared for a gravely disabled senior citizen who lives on our corner -- we rejoiced when she was finally hospitalized last January and seemingly put on a track towards conservatorship. When the system broke down, and she was re-released to the streets in May, we have again taken up advocacy on her behalf. That said, a uniform interpretation of "gravely disabled" would have assisted us in helping her access services she desperately needs but cannot cognitively understand.

As to my background, I am one of the founding board members of Housing Works in Hollywood; in years past I served on the Los Angeles County Bring LA HOME! Blue Ribbon Panel on Ending Homelessness, and served on the board of Faith Matters – an interfaith advisory group to People Assisting the Homeless. In addition, I served on the Los Angeles County's Safe Surrender Task Force, resulting in the creation of effective public policies encouraging women to not abandon, but safely surrender, unwanted babies at local hospitals and fire stations.

I am also a former board member of The Wall/Las Memorias Project, which honored me for my work in 2014. In addition, I am a former chair of the Community Advisory Panel of the LAUSD HIV/AIDS Education and Prevention Unit.

And, from my bio:

*From 1994-2005, Rev. Cooper Ledesma served the California Council of Churches, the public policy and education arm of the mainline Protestant community in California, as Board Chair and later as program staff. She directed statewide projects on interfaith relations, public/private partnerships, welfare reform implementation, and faith based child care. From 2005-2006 she worked as a project specialist at the USC Center for Religion and Civic Culture on issues relating to communities of faith and preschool for all, her strong expertise. During her tenure with the Council Kathy authored First Fruits for California's Working Poor, a study guide for congregations, about the lives and conditions of those participating in the state's CalWORKs programs.*

*In 2005, Kathy received the Boutilier Award for Distinguished Ecumenical Service from the Southern California Ecumenical Council.*

*Kathy received her A.B. degree from Occidental College and her M. Div. from the Claremont School of Theology. She was married to the Rev. Rene Ledesma for 26 years, until his death in 2014. She is the proud mother of two young adult sons, James and Joshua.*

Thank you for your consideration. If I can provide further information I can be reached at revkathy@hollywoodumc.org or at 323-874-2104 ext. 201

Sincerely,

Rev. Kathy Cooper Ledesma

--

*Rev. Kathy Cooper Ledesma, Senior Pastor*

*Hollywood United Methodist Church*

*One church, two campuses:Hollywood and Toluca Lake*

--

*Rev. Kathy Cooper Ledesma, Senior Pastor*

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*One church, two campuses:Hollywood and Toluca Lake*

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*Rev. Kathy Cooper Ledesma, Senior Pastor*
*Hollywood United Methodist Church*
*One church, two campuses:Hollywood and Toluca Lake*

**Kathy Jones**

**From:** Kerry Morrison <Kerry@hollywoodbid.org>
**Sent:** Monday, September 25, 2017 3:25 PM
**To:** Canetana Hurd
**Subject:** Caroline's number

Canetana, I realize I don't have Caroline's number written down. Can you give it to me, or have her call me at 323-463-6767

---

**KERRY MORRISON**
*Executive Director*

[ Hollywood Property Owners Alliance ]
6562 Hollywood Blvd | Los Angeles, CA 90028
323.463-6767 | kerry@hollywoodbid.org | onlyinhollywood.org

**Kathy Jones**

**From:** Mary Marx
**Sent:** Monday, September 25, 2017 3:08 PM
**To:** Caroline Kelly
**Cc:** Barbara Wilson;Kerry Morrison;Lawrence Lue;Canetana Hurd;Brittney Weisman
**Subject:** RE: Mental Health Commission Information

Hi Caroline –

See below for responses.

**From:** Caroline Kelly [mailto:chairlamhc@gmail.com]
**Sent:** Monday, September 25, 2017 1:05 PM
**To:** Mary Marx
**Cc:** Barbara Wilson; Kerry Morrison; Lawrence Lue; Canetana Hurd; Brittney Weisman
**Subject:** Fwd: Mental Health Commission Information

Hi Mary,

Thank you for sending this. I forwarded it to Kerry and Barbara, our other ad hoc members and Kerry had the following questions about the material. We are having the call at 3pm. I am not sure if you are able to join us or maybe have someone else join. If not, it would be great if you could respond to some of these questions or let us know a time to follow up about this information. The questions are in red, below.

Thanks,

Caroline

Conference call info:

Monday, September 25 @3 pm

888 204 5987

#9639884

As requested.

This is as much info as we have from CCL . They have not verified a number of 6 bed facilities that potentially only served DD.

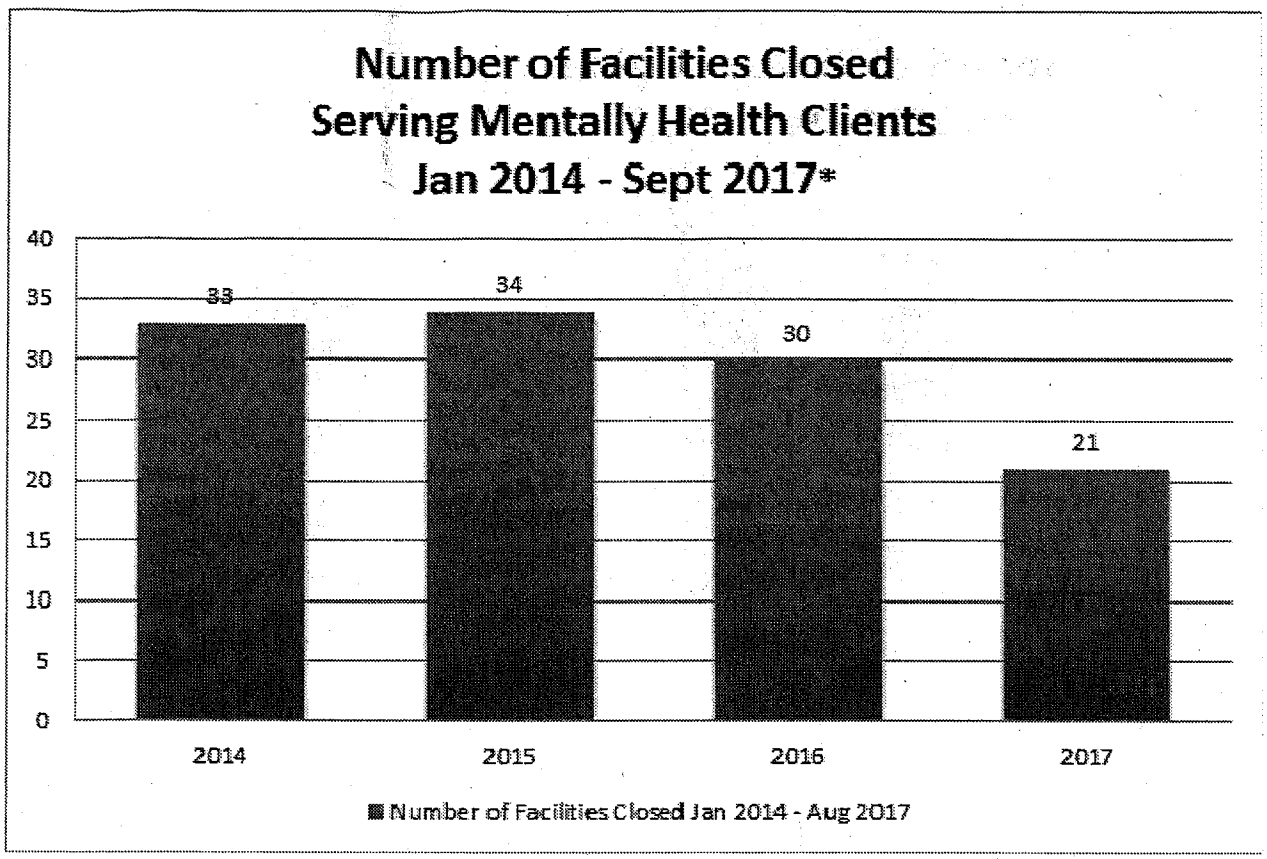
Table 1. Closures by Category Jan 2014 – Aug 2017

| Closed Reason | Number of Facilities | Facility Capacity |
|---|---|---|
| Closed - Licensee Initiated | 99 | 986 |
| Closed - Agency Initiated | 17 | 157 |
| Closed - Non-payment | 2 | 12 |
| Totals | 118 | 1155 |

Table 1 represents the number of facilities and the facility's capacity that have closed since 2014. It should be noted that CCL has additional categories that are used, such as when there is a change of ownership or the relocation of a facility; however, these are considered changes that often do not result in the actual closure of a board and care facility.

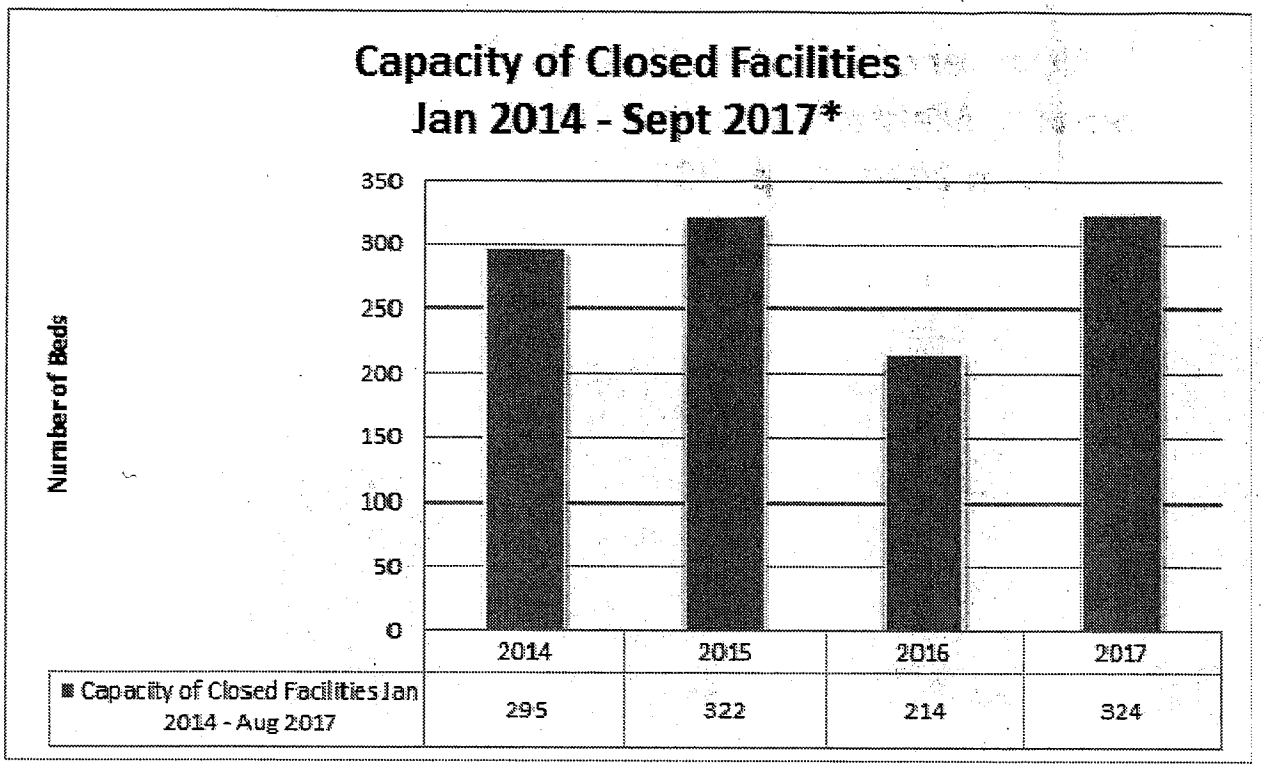
Are these all facilities, or just Adult Residential Facilities that serve mentally ill?
Reading this, I would see that there was a loss of 1,115 beds? **These are mostly ARFs, but included a few Social Rehab Facilities and one Adult Day Program that would take MI.**

Chart 1. Number of Facilities Closed Serving Mental Health Clients




This looks like a chart for the info provided in Table 1? This shows 118 facilities closed – which is the number above. However, in this one, the asterisk indicates that these facilities primarily serve DD population. That is not what the title says. We need some clarification. Also, it would be important to know how many converted away from a MI population, to a DD population. **The * was placed before updating. No * is needed for this chart. There was no data provided on how many converted; however, CCL reports that this is not really occurring. They are seeing more closures than conversions.**

Chart 2. Capacity of Closed Facilities




Again, this is the number of beds presented in Table 1, but we have the same questions as I listed above. **This includes all facilities that have closed in LA not just the ones that treat MI.**

## Kathy Jones

**From:** Caroline Kelly <chairlamhc@gmail.com>
**Sent:** Monday, September 25, 2017 2:11 PM
**To:** Barbara Wilson;Kerry Morrison;Brittney Weisman;Canetana Hurd
**Subject:** Powerpoint on integrated care housing and additional information re board and cares
**Attachments:** ATT00001.htm; Integrated Care Team - A New Model 9-25-17.pptx

**Follow Up Flag:** Follow up
**Flag Status:** Flagged

This presentation was given earlier today about DMH's proposed approach to housing and I thought I would pass it on. I'm not sure that we can incorporate any of it into our presentation but it is useful background information.
Maria Funk, Ph.D. gave the presentation.

I also learned the following from Robin Kay today. We should meet with her and possibly Maria Funk before we finalize our report and submit our proposals so we can know what things are actually being proposed and what things have already been shot down and why.

DMH has a solicitation out to Board and Cares that would provide an additional $25 dollars to the $33 dollar rate. They have a total of 2 million available through Whole Person Care.

Also, under measure B-7 of the homeless recommendations, there may be funding for Board and cares.
RECOMMENDATION Direct the Los Angeles Homeless Services Authority, in collaboration with the Department of Health Services (DHS), Department of Mental Health (DMH), Probation Department, Department of Children and Family Services (DCFS), and Sheriff (LASD) to develop and implement a plan to increase the interim/bridge housing stock across the County, including identification of funding.
http://priorities.lacounty.gov/wp-content/uploads/2016/03/HI-Report-Approved2.pdf

# Integrated Care Team: A New Model of Services in Permanent Supportive Housing

Maria Funk, Ph.D.
District Chief
mfunk@dmh.lacounty.gov

# Framing for the New Model

- According to the 2017 Los Angeles County homeless count, there are 57,000 individuals/ families that are homeless on any given day. 30% have a mental illness.

- Permanent Supportive Housing (PSH) is a SAMHSA Evidence Based Practice that combines low-barrier affordable housing with supportive services that targets individuals/families that are homeless and have a disability/chronic health condition.

- Health Agency (Departments of Mental Health, Health Services and Public Health) along with other key stakeholders were charged with developing an integrated model of supportive services based on best practices.

# Framing for the New Model

- In November 2012 DHS launched Housing For Health with an infusion of funding for homeless services and housing resources targeting high utilizers of County health services.

- Every client that is matched to a housing resource (subsidy) is also assigned to an Intensive Case Management Services (ICMS) provider.
  - Case rate of $450/client/month
  - Up to 1:20 client to case manager ratio
  - Comprehensive housing related supportive services.
  - Site based and mobile teams.
  - Services are not time-limited

- Housing developers and property managers prefer this model.

- Success of this program resulted in it being adopted by the County as a best practice.

# Framing for the New Model

- On February 9, 2016, County Board of Supervisors adopted 47 strategies to combat homelessness, one of which was to develop supportive services standards for formerly homeless individuals/families in permanent housing.

- On March 7, 2017 Los Angeles County voters approved a ¼ cent tax which provides a revenue stream of approximately $355 million/year to pay for homeless resources and services.

- Board of Supervisors mandate to ensure all people in permanent supportive housing receive appropriate supportive services.

# Framing for the New Model

- **No Place Like Home**
  - $2 billion statewide bond
  - Los Angeles is estimated to receive $700 million
  - Depending on the leveraging, 1,400 to 5,100 units will be developed for those with mental illness
- **Proposition HHH** – City of LA has committed to developing 1,000 units per year (80% for a chronically homeless population)
- **County Affordable Housing Motion** -- $20 million first year increases to $100 million over 5 years

# Framing for the New Model

- Model includes the following principles:
  - Maximizing leveraging of each Department's resources and of MediCal
  - Increasing efficiencies
  - Maximizing the expertise of each Department

# What is the Problem this New Model will Address?

- Through the MHSA Housing Program/Special Needs Housing Program -- DMH invested $145 million in the development of PSH
- 53 housing developments countywide with 1,130 MHSA units
- 34 housing developments currently occupied providing 786 units of PSH
- 2,016 tenant based subsidies (e.g. Shelter Plus Care)

# What is the Problem this New Model will Address?

- DMH has not had dedicated funding to provide services to all tenants of PSH.
- Some services are not field-based or provided on-site of the housing.
- Services are connected to client not the housing resource.
- When a client becomes disconnected from services, there is no one to respond when there is a housing related problem (e.g. hoarding, isolation, disrupting other tenants, non-payment of rent).
- Many different mental health agencies providing services to the tenants in one PSH building – causes confusion for property manager.

# County's Proposed New Model of Supportive Services

Supportive Services via an Integrated Care Team (ICT) Include:

- Intensive Case Management Services
- Mental Health Services
- Substance Use Disorder Services

# Over-Arching Goals of the Model

- Provide comprehensive services to tenants of PSH to achieve long-term stability and improved health and well-being.
- Implement a standardized and easily replicable mechanism to ensure that supportive housing tenants have access to ICMS, specialty mental health and substance use services.
- Maximize each Department's ability to leverage MediCal revenue to offset the cost of services including through Whole Person Care, Drug MediCal waiver and mental health MediCal.

# Intensive Case Management Services

- ICMS services will be provided by homeless services providers under contract with DHS
- All clients matched to permanent supportive housing will receive ICMS services
- ICMS services are provided onsite at project based PSH and by mobile teams at scattered site PSH

# ICMS Includes

- Assist client with obtaining necessary documentation
- Assist with completing and submitting rental subsidy application
- Assist with housing search
- Eviction prevention support and intervention
- Ongoing client support and home visits
- Assist client with accessing and keeping appointments for health, mental health and SUD services
- Assist with life skills
- Assist with educational and volunteer opportunities
- Transportation
- Assist with obtaining health and income benefits

# Mental Health Services

- Housing Full Service Partnership (FSP) services will be provided by specialty mental health providers under contract with DMH funded at $8,000/client.
- It is estimated that approximately 30% of homeless individuals have a serious mental illness and will be offered FSP services.
- FSP services are focused on helping clients manage the symptoms of their mental illness and assist them with their mental health wellness and recovery goals. Services include:
  - Individual/Group Therapy/Counseling
  - Medication Support
  - Crisis Intervention
  - Referrals and Linkage

# Substance Use Disorder (SUD) Services

- Client Engagement and Navigation Services (CENS) will be provided by SUD providers under contract with Substance Abuse Prevention and Control (SAPC).
- It is estimated that approximately 30% of individuals that move into permanent supportive housing will receive CENS services.
- CENS includes outreach and engagement, screening and referral, SUD service navigation, and care coordination to improve access to SUD services.
- Outpatient and Intensive Outpatient SUD services, including individual and group counseling.

## Estimated Number of Housing Units that will Receive ICT Services in Fiscal Year 2017-18

- MHSA Housing Program Existing Units – 786
- Measure H Units – 2,500 new units of PSH.
  - 30% or 750 units will be dedicated to those with mental illness

# Timeline

- July 2017
  - DMH begins implementing new model in MHSA Housing Program existing units
- July 1, 2017
  - Measure H Implementation Begins
- July 14, 2017
  - DMH released Statement of Eligibility and Interest for Housing FSP
- September 2017
  - DMH makes contract decisions and begins contracting process
- September 2017
  - as new permanent supportive housing become available, Integrated Care Team (ICT) services will begin

# Outcome Metrics

- Number of clients linked to Intensive Case Management Services
- Number of clients receiving Housing Full Service Partnership services
- Number of clients referred to substance use disorder treatment, number who enter treatment, and number who complete treatment
- Number of federal rental subsidies
- Number of local rental subsidies
- Number of clients housed
- 12-month housing retention percentage
- 24-month housing retention percentage